Under the leadership of Intermountain Healthcare’s Behavioral Health Clinical Program, this Care Process Model (CPM) was developed by a multidisciplinary team that included primary care providers (PCPs), mental health specialists, social workers, and substance use disorder treatment specialists. Based on national guidelines and shaped by local expert opinion, this CPM provides practical strategies for appropriate diagnoses and effective treatment of substance use disorders (SUDs) including alcohol, prescription medications, illicit drug, and tobacco use disorders.

**Why Focus ON SUBSTANCE USE DISORDER?**

- **Alcohol abuse goes undetected.** At least 38 million adults in the U.S. drink too much alcohol, but only 1 in 6 talk with a healthcare provider about alcohol use. Alcohol screening and brief counseling can reduce drinking by as much as 25% in people who drink too much.\(^{\text{COC}}\)

- **Patients are under treated and need both medical and mental health treatment.** Only about 10% of the 23.5 million U.S. adults with SUD receive needed addiction treatment.\(^{\text{PAl}}\) Compared to people without SUD, patients with SUD have a greater risk of congestive heart failure (9 times), liver cirrhosis (12 times), and pneumonia (12 times) and often have mental health disorders as well. Research indicates that integrated care for these patients results in better health outcomes and supports a continuing role for primary care in coordination with specialty treatment.\(^{\text{SAM}}\) During and after specialty treatment, 2 or more primary care visits in a six-month period have been shown to improve abstinence by 50%, and those with related medical conditions are 3 times more likely to achieve remission over five years.\(^{\text{SAM}}\)

- **SUD is costly.** The NIH estimates that the economic cost to society of disorders related to tobacco, alcohol, and illegal drug use is $559 billion annually. Illicit drug use alone accounts for $193 billion in health care, productivity loss, crime, incarceration, and drug enforcement.\(^{\text{NDIC}}\)

- **SUD has a high mortality rate.** The estimated annual U.S. deaths attributable to: cigarette smoking — 443,000 deaths (leading preventable cause of death in the U.S.)\(^{\text{SAM}}\); alcohol — 88,000 deaths \(^{\text{COC}}\); and prescription drugs — 40,000 deaths (second-most abused category of drugs in the U.S. after marijuana).\(^{\text{PAl}}\)

**What’s New in this UPDATE?**

- Screening algorithm for adolescents ages 12 through 18
- Information on the CRAFFT screening tool for adolescents
- New information on naloxone use for opioid overdose
- Updated recommended patient and family education for brief interventions

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**EXECUTIVE SUMMARY**

**ALGORITHMS:**

- Algorithm 1: Adult Integrated Process for Primary Care
- Algorithm 2: Adolescent Integrated Process for Primary Care
- Algorithm 3: Specialty SUD treatment

**TERMINOLOGY AND DIAGNOSTIC CRITERIA**

**SUBSTANCE-SPECIFIC CONSIDERATIONS**

**SPECIAL POPULATIONS**

**MANAGEMENT IN PRIMARY CARE**

**SPECIALTY TREATMENT**

**MEDICATION MANAGEMENT**

**ISSUES AND CHALLENGES**

**MEASURING SUCCESS**

**REFERENCES**

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**GOALS AND MEASURES**

To improve care for our patients with SUD, this CPM will track measures in the following domains:

- **Patient identification:** number of patients identified via screening
- **Patient participation in treatment:** number of referrals and follow-ups
- **Implementation:** number of facilities with processes and services that support the care outlined in this CPM
- **Clinical outcomes:** prescribing patterns and patient outcomes
- **Healthcare utilization:** number of patients receiving recommended interventions

See page 31 for details on these measures.
EXECUTIVE SUMMARY

A complex problem requiring an integrated solution

SUDs are complex mental health disorders, and patients with SUDs frequently have comorbid mental and physical problems. These patients often require multidisciplinary teams that can treat the whole person:

• More than 8.9 million adults have comorbid mental health conditions and substance use disorders. Only 7.4% of these patients receive treatment for both mental health and substance use disorders, and 55.8 percent receive no treatment at all.\(^{SAM4}\)

• Patients with SUD often have one or more physical health problems, such as lung disease, hepatitis, HIV/AIDS, cardiovascular disease, and cancer.\(^{SAM5}\)

For patients with SUD and one or more comorbid disorders, integrated care can improve outcomes and reduce cost more effectively than traditional care (separate, siloed primary care, mental health, and substance use disorder treatment).\(^{SAM5}\)

Aligning philosophy and practice: Intermountain’s strategy for SUD care

At Intermountain, mental health integration (MHI) in primary care, which has provided 17 years of experience and validated results, helps organize and support the integrated care described in this CPM. Team-based, outcome-oriented MHI aligns with SUD care that integrates mental health, substance use disorder, and primary care service to advance the goals of Intermountain’s Triple Aim:

• Improve the quality of health. Clinical trials have demonstrated that when a patient has a substance use disorder problem and one or more comorbid disorders, integrated care results in better clinical outcomes than traditional treatment delivery.\(^{SAM5}\)

• Enhance the patient experience. Intermountain’s ultimate goal is to improve the lives of our patients. From identifying a patient’s alcohol use disorder in primary care and changing his behavior, to providing a full treatment program and medical care to a person with opioid use disorder and comorbid physical and mental health problems, an integrated approach enables us to treat the whole patient. This enhances patients’ experiences and engages them in caring for their own health and wellbeing.

• Lower the cost of care. The 2014 Milliman American Psychiatric Association Report found that medical costs for patients with mental health disorders are 2 to 3 times higher than patients without these types of disorders. In 2012, the additional costs were estimated to be $293 billion in the U.S. (and most of these costs were attributed to medical services, not mental health treatment). According to the report, effective integration of medical and mental health care could save $26 to $48 billion in general healthcare costs every year.\(^{MEL}\)

MHI’s collaborative, team-based approach is well suited to the complexity of SUD assessment and management.
A process for successful integration of care

SUD patients come into the Intermountain system in many ways: the patient may seek services, a family member may bring them in, a physician may identify a problem, an employer may identify a problem, and so on. Intermountain’s process supports patients however they come into the system. Key elements of our process include:

- **Identifying the appropriate level/site of care for each patient.** Intermountain follows the American Society of Addiction Medicine (ASAM) Levels of Care model to place patients into the appropriate level of care. Referral to level of care is based on a careful assessment of the patient’s physical and mental needs, substance use patterns, social situation, financial needs, and other factors. The preferable level of care is the least intensive level that meets the treatment goals and provides a safe environment for the patient. See page 24 for full descriptions of treatment levels.

### ASSESSMENT

#### Treatment intensity increases if severity increases

<table>
<thead>
<tr>
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</tr>
</tbody>
</table>

#### Treatment intensity decreases as condition improves

- **Ensuring a valid and consistent method for screening and referral — SBIRT.** Identification and management of risky substance use or SUD follows the **SBIRT** model — Screening, Brief Intervention, and Referral to Treatment. **SBIRT** is a comprehensive, practical, and integrated approach to SUD screening and treatment.

#### Validation of SBIRT

Although the long-term effects of SBIRT have not yet been thoroughly validated, simulation models have shown positive results. Research shows that brief interventions (based on appropriate screening) for **at-risk drinkers** were often as effective as more extensive treatments; in the ED, a brief intervention was associated with decreased alcohol consumption and reduced risk of readmission.

Studies on the effect of brief intervention on **drug use** are also showing promising results: one study found that brief intervention in a clinical setting can reduce cocaine and heroin use and appeared to facilitate abstinence at 6 months; another study found that brief interventions by PCPs can reduce excessive benzodiazepine use.

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**Screening**

- Systematic screening in normal routine patient care using:
  - Adult tools (see page 16):
    - Intermountain-Modified NIDA Quick Screen
    - ASSIST-based Assessment
  - Adolescent tool: CRAFFT (see page 6):

**Brief Intervention**

- For patients with moderate or high risk, a brief intervention to educate the patients on the dangers of high-risk behavior and motivate the patient to reduce risky behaviors during a single session or during multiple sessions.

**Referral to Treatment**

- Referral to treatment, with flexible options available in your community to encourage patients to follow up on treatment and to identify the appropriate treatment program.

**Tools:**

- Patient Summary that provides patients with necessary information as part of the referral
- Inventory of SUD Resources that lists resources by region
- Clinician education on resources in your communities
**ALGORITHM 1: ADULT INTEGRATED PROCESS FOR PRIMARY CARE**

**Screening | Brief Intervention | Referral to Treatment**

**SUD Prevention: Establish clinic process and culture (a)**

**SCREEN patients age ≥ 18 at preventive care visits with the Intermountain-Modified NIDA Quick Screen (page 18)**

“Never” to all questions

END. EDUCATE patient. Reinforce abstinence and prevention.

**ASSESS patients with risk factors, drug-seeking behavior, or other presentation (b)**

(+1) on ≥ 1 question (anything but “Never” to any question)

**ADMINISTER the ASSIST-based Assessment (d)**

0–10 points on alcohol OR 0–3 points on other substances

Comorbidities? (e) Yes → Consider higher level of risk. See algorithm 2, page 6.

No → TREAT on a continuum and REASSESS regularly (see page 6)

**MODERATE Risk**

PCP, MH provider, or MHI team member performs brief intervention (and may refer)

- Perform brief intervention. (f)
- Share patient scores via the Substance Use Response and Report Card for Patients.
- Educate patient on risky behaviors.
- If alcohol or tobacco, consider referral to treatment and/or mutual-help groups. (g)
- If drugs, refer to treatment and/or mutual-help groups. (g)
- Prescribe medications if applicable. (h)
- Treat comorbidities.
- Schedule a follow-up appointment in 2–4 weeks.

**HIGH Risk**

PCP, MH provider, or MHI team member performs brief intervention and refers to treatment

- Perform brief intervention. (f)
- Refer to treatment and/or mutual-help groups. (g)
- Provide a copy of the Patient Summary. (g)
- Share patient scores via the Substance Use Response and Report Card for Patients.
- Educate patient on risky behaviors.
- Prescribe medications if applicable. (h)
- Treat comorbidities.
- Schedule a follow-up appointment in 2–4 weeks.

**INTERMOUNTAIN measures:**

- Access to care
- Whether the patient follows through with referral to treatment

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Who administers?

Readiness to change.

If the patient appears to be intoxicated or impaired, determine safety to drive.

Education.

Establish and communicate a clinic focus on mental health and SUD prevention and identification by:

• Setting up patient education displays with SUD prevention materials (see page 32 for ordering instructions).
• Discussing SUD screening and treatment at regular staff trainings.
• Establishing open communication with patients about substance use.

(b) Patients to assess

If any of the following is present, consider the patient at risk for substance use disorder and administer the ASSIST-based Assessment:

• Answers “Yes” to any of the substance use questions on the Live Well Lifestyle and Health Risk Questionnaire.
• Answers “Yes” to the substance use questions on the Mental Health Integration (MHI) packets (question 7 of the Behavioral Health Intake Questionnaire portion of the Adult Baseline packet).
• Presents with risk factors. See page 14 for considerations for special populations.
• Presents with substance use disorder. Patients may seek out services or be referred [e.g., through an Assistance Program (EAP)]. The clinician may also suspect substance use based on patient presentation.
• Shows signs of drug-seeking behavior. See page 13 as well as the CPM, Prescribing Opioids for Chronic Non-cancer Pain, for information on managing opioid therapy.
• Based on clinical suspicion.

(c) Addressing immediate stability, safety concerns

Patients may present to the office/clinic with immediate safety concerns such as acute intoxication or suicidal ideation. Consider the following:

• If the patient appears to be intoxicated or impaired, determine safety to drive. Consider contacting family or other transportation options.
• If the patient is expressing suicidal or homicidal ideation or severe psychiatric symptoms due to substance intoxication or impairment (e.g., psychosis, paranoia), consider further assessment using MHI staff or facilitate evaluation in the ED. (See the Suicide Prevention CPM, which includes information about Intermountain’s Involuntary Commitment guidelines.)
• If any of the following is present, consider the patient at risk for substance use disorder and administer the ASSIST-based Assessment.

(d) ASSIST-based Assessment (see page 18)

Intermountain’s ASSIST-based Assessment is derived from the ASSIST V3.0 Assessment.

• What is it? An interviewer-administered, 8-question assessment developed by the World Health Organization (WHO) that assesses for all levels of problem or risky substance use. Screening takes about 10 minutes for most patients.
• Who administers? Care managers, MHI team members, BH specialists, and other clinicians trained on the tool.
• Can I use it with adolescents? The ASSIST has been validated for patients age 18–60. According to WHO, ASSIST is feasible for use with adolescents; however, the scores that determine risk level may not be appropriate. NIDA2 For example, it identifies a person who consumes alcohol once weekly as low risk, but any adolescent drinking puts the patient at greater risk. Use clinical judgment to determine appropriate levels of care for adolescents. See Special Populations: Adolescents on page 14.

(e) Comorbidities

A variety of physical diseases commonly co-occur with SUD, including HIV, hepatitis C, cancer, and cardiovascular disease. NIDA3

Drug addiction is itself a mental health disorder. People with mood, anxiety, and antisocial disorders are twice as likely to also have a substance use disorder compared to those without. NIDA4

Any comorbidities increases the patient’s risk level and requires multidisciplinary care to treat the whole patient.

(f) Brief intervention (see page 18)

The brief intervention takes between 5 and 15 minutes and can be adapted to the time you have available. Brief intervention includes:

• Feedback. Give feedback about screening results using the Substance Use Response and Report Card for Patients: discuss the risks of negative health effects to the patient’s presenting health concerns.
• Information. Inform the patient about safe consumption limits; offer advice about change.
• Education. Use Intermountain education materials to guide the conversation.
• Readiness to change. Assess patient’s readiness to change using the Live Well Readiness Worksheet and the Substance Use Behavior Change Action Plan.

(g) Referral to treatment (see page 23)

See the Algorithm 3: Specialty SUD Treatment on page 8 for referral guidelines.

• Print a Patient Summary from iCentra (page 23) for the patient.
Each patient assessed and diagnosed with an SUD should receive a written “dosing recommendation” that clarifies the treatment plan for the patient. NQF
• Consider referral to mutual-help groups, addiction specialist, ED for managed withdrawal (for patients with dependence), or other specialty treatment.

(h) Medication management (see page 28)

Prescribe medications, if applicable, for patients with chemical/physical dependence who endorse abstinence as a goal, and only in coordination with psychosocial treatment.
ALGORITHM 2: ADOLESCENT INTEGRATED PROCESS FOR PRIMARY CARE

SUD Prevention: Establish clinic process and culture (a)

SCREEN patients age 12 to 18 at preventive care visits with the CRAFFT, PART A (b)

“NO” to all questions

ONLY ASK first question in CRAFFT, Part B.

“YES” to ANY question

ADMINISTER the full CRAFFT, Part B (b)

“YES” answer to ≥2 questions in Part B?

EDUCATE
• Discuss the risks of riding in a vehicle with anyone under the influence. Recommend NIH fact sheet, Drugged Driving
• Provide other applicable patient education printed materials (see page 22)
• Follow up at next appointment to confirm that risk no longer exists.

END. RESCREEN annually.

PERFORM brief Intervention and REFER
PCP, MH provider, or MHI team member performs the following:
• PERFORM brief intervention. (d)
• EDUCATE patient on risky behaviors (see patient education resources on page 22).
• If alcohol or drugs, REFER for further treatment evaluation. (e)
• If tobacco, CONSIDER nicotine replacement therapies.
• PRESCRIBE medications if applicable. (f)
• TREAT comorbidities.
• SCHEDULE a follow-up appointment in 2–4 weeks.

TREAT on a continuum (see page 8)

Patient age 12 to 18 PRESENTS intoxicated or impaired; obvious risk; or requesting treatment (c)

Stable, safe?

Yes

As appropriate, contact police, call family, or refer to ED. (d)

No

END.

RESCREEN annually.

Intermountain measures:
• Access to care
• Whether the patient follows through with referral to treatment
ALGORITHM NOTES

(a) Clinic process and culture to support prevention
Establish and communicate a clinic focus on mental health and SUD prevention and identification by:
- Setting up patient education displays with SUD prevention materials (see page 32 for ordering instructions).
- Discussing SUD screening and treatment at regular staff trainings.
- Establishing open communication with patients about substance use.
- For all adolescents, providing Intermountain’s Preventive Care for Teens and Young Adults fact sheet, and discussing the risks of substance use.

(b) Using the CRAFFT screening tool
The CRAFFT screening tool is a brief, 2-part questionnaire for screening adolescents for high-risk alcohol and substance use disorders.
- The tool should be used to determine the need for patient education or treatment interventions.
- Part A of the tool includes 3 questions (see below). A “yes” answer to any of the 3 questions should be followed up with Part B of the screen. A “no” answer to both should be followed up with asking ONLY the first question in part B and educating the patient on risks if that question is answered positively.
- Part B of the tool includes 6 questions (see below). A “yes” answer to 2 or more questions should be followed up with appropriate treatment interventions per this CPM.

(c) Addressing immediate stability, safety concerns
Patients may present to the office/clinic with immediate safety concerns such as acute intoxication or suicidal ideation. Consider the following:
- If the patient appears to be intoxicated or impaired, determine immediate safety factors. Consider contacting family if not present at the time.
- If the patient is expressing suicidal or homicidal ideation or severe psychiatric symptoms due to substance intoxication or impairment (e.g., psychosis, paranoia), consider further assessment using MHI staff or facilitate evaluation in the ED. (See the Suicide Prevention CPM, which includes information about Intermountain’s Involuntary Commitment guidelines.)

(d) Brief intervention (see page 20)
The brief intervention takes between 5 and 15 minutes and can be adapted to the time you have available. Brief intervention includes:
- Feedback. Give feedback about screening results; discuss the risks of negative health effects to the patient’s presenting health concerns.
- Education. Use Intermountain education materials to guide the conversation.
- Readiness to change. Assess patient’s readiness to change using the Live Well Readiness Worksheet and the Substance Use Disorder: Behavior Change Action Plan.

(e) Referral to treatment (see page 23)
See the Specialty SUD Treatment algorithm on page 4 for referral guidelines.
- Print a Patient Summary from iCentra (see page 23) for the patient. Each patient assessed and diagnosed with an SUD should receive a written “dosing recommendation” that clarifies the treatment plan for the patient. Not.
- Consider referral to adolescent-specific recovery supports, addiction specialist, ED for managed withdrawal (for patients with dependence), or other specialty treatment.

(f) Medication management (see page 28)
Prescribe medications, if applicable, for patients with chemical/physical dependence who endorse abstinence as a goal, and only in coordination with psychosocial treatment.

CRAFFT Adolescent Screening Tool

The CRAFFT was developed by the Center for Adolescent Substance Abuse Research (CeASAR®) at Boston Children’s Hospital and is recommended by the American Academy of Pediatrics’ Committee on Substances Abuse for use with adolescents. CRAFFT is a validated tool for alcohol and substance misuse. The title, CRAFFT, is a mnemonic acronym for key elements in the six screening questions in Part B (CAR—RELAX—ALONE—FORGET—FRIENDS—TROUBLE).

Link to the Provider Guide for tips on how to use, score, and provide interventions for those at risk. (see appendix A of the Provider Guide for a copy of the tool, or access the links below)

You can download the following resources at http://www.ceasar.org:
- Downloadable, self-administered and clinician-administered version of the CRAFFT
- Order form for pocket-sized CRAFFT cards for office use
- The CRAFFT forms in other languages (Spanish, Portuguese, Hebrew, French, Czech, Khmer, Russian, Turkish, Vietnamese, Haitian Creole, Laotian, Chinese, and Japanese)
ALGORITHM 3: SPECIALTY SUD TREATMENT

Substance Use Disorder Referral to Specialty Care:
Trained MH clinician at a Dayspring clinic or other site (e.g., MHI clinician, specialty clinician, etc.)

ADMINISTER LOCI multidimensional assessment (a) to determine treatment level

CREATE treatment plan (b)

TREAT on a continuum (c)

Treatment intensity increases if disease severity increases

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Treatment intensity decreases as condition improves

FOLLOW UP and AFTERCARE (d)
- Provide or encourage continuing care (aftercare).
- Administer the Functional Disability Rating Scale (e) at discharge, weekly in intensive outpatient settings, monthly in standard outpatient settings, and annually after patient goes into remission.

Intermountain measures the amount of time between the assessment and the admission to treatment.
### (a) LOCI multidimensional assessment

Based on ASAM Treatment Criteria, the Adult Level of Care Index-3 (LOCI-3) OR Adolescent Level of Care Index-2R assesses:
- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications
- Emotional, behavioral, or cognitive conditions and complications
- Readiness to change
- Relapse, continued use, or continued problem potential
- Recovery, living environment

Order copies of the LOCI from [https://www.changecompanies.net/](https://www.changecompanies.net/). Allow 4 – 6 weeks for delivery.

### (b) Treatment planning

Based on multidimensional assessment, develop a treatment plan. The treatment plan should include these elements:
- Treatment team
- Patient goals
- Discharge or transition criteria
- Patient and family strengths
- Obstacles and barriers
- Interventions and methods of care

For adolescents, refer to Adolescent Alcohol and Drug Use Interventions Clinical Guideline for stratification levels and targeted interventions based on behavior and other factors.

### (c) Ongoing assessment and treatment levels

**Ongoing assessment:** Perform ongoing assessment based on the treatment plan, clinician notes, patient progress, and etc. Update the treatment plan to reflect patient progress as needed. Be sure to include patient challenges in the treatment and clinician notes (not just successes).

**Treatment levels:** Not all levels of care are available in all areas. The levels of care identified are intended to provide an overarching view of the types of care available to patients. The treatment plan must be individualized based on the patient’s needs, insurance, and available services. See Intermountain’s Inventory of Substance Use Disorder Resources for resources in your area.

<table>
<thead>
<tr>
<th>ASAM level</th>
<th>Primary Care</th>
<th>Specialty Care (SUD or BH)</th>
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<tbody>
<tr>
<td>Early Intervention (SBIRT)</td>
<td>Outpatient Services (e.g., specialty clinics, suboxone clinics, outpatient withdrawal management or detox)</td>
<td>Intensive Outpatient Services (e.g., Dayspring evening clinic, outpatient withdrawal management)</td>
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### (d) Aftercare

Returning to everyday life after SUD treatment is challenging, and relapse is an ever-present danger. An aftercare program’s primary purpose is to promote community resources and natural support systems to meet the needs of patients to function autonomously in their natural environment. Aftercare is usually provided 1 day per week for 1 hour as a support to outpatient services. Patients attend for as long as needed (usually 10 weeks or more). In Salt Lake, Dayspring at LDS Hospital provides an aftercare for adults and Primary Children’s provides aftercare for children. Other options include mutual self-help groups, relapse prevention groups, continued individual counseling, and psychiatric services (especially important for clients who continue to require medication).

### (e) Functional Disability Rating Scale

The Functional Disability Rating Scale is a measurement of functional disability and impairment due to psychiatric symptoms. It consists of 3 functional disability impairment questions. It currently exists in HELP2 Hot Text and will also be available in iCentra.

It is also available on [intermountain.net](http://intermountain.net) and [intermountainphysician.org](http://intermountainphysician.org) from the Behavioral Health Clinical Program topic page on Substance Use Disorder.
Addiction: “A primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

“Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.” – ASAM

TERMINOLOGY AND DIAGNOSTIC CRITERIA

Uniform terminology
Uniform terminology helps clinicians interpret criteria and communicate appropriately and consistently with patients and other clinicians. ASAM provides the following definitions for SUD-related terminology:

- **Alcoholism**: General but not diagnostic term, often used to describe alcohol use disorder, but sometimes used more generally.
- **Chemical dependence**: General term relating to the psychological and/or physical dependency on ≥1 psychoactive substances.
- **Harmful use**: Use in the absence of addiction but with health consequences.
- **Hazardous use (or at-risk use)**: Use that increases the risk for health consequences.
- **Impairment**: Dysfunctional state resulting from use of psychoactive substances, or mental, emotional, or cognitive problems.
- **Overdose**: Consumption of a dose much larger than that either habitually used by the patient or ordinarily used for treatment of an illness; likely to result in a serious toxic reaction or death.
- **Physical dependence**: Manifested by a drug-class specific withdrawal syndrome produced by cessation, dose reduction, decreasing blood level of the drug, and/or an antagonist.
- **Psychological dependence**: A subjective sense of need for a specific psychoactive substance.
- **Rehabilitation**: Restoration of optimal state of health by medical, psychological, and social means for an alcoholic or addict, a family member, or a significant other.
- **Relapse**: Recurrence of signs and symptoms of active addiction in an individual who has established abstinence or sobriety.
- **Remission**: Abatement of signs and symptoms that characterize active addiction.
- **Sobriety**: Sustained abstinence with a clear commitment to and active seeking of balance in the biological, psychological, social, and spiritual aspects of health and wellness that were previously comprised by active addiction.
- **Substance use disorder (SUD)**: See DSM-5 definition/criteria on page 11.
- **Tolerance**: State in which exposure to a drug results in diminution of drug’s effect(s) over time.
- **Treatments**: See page 27 for definitions of types of treatments.
- **Withdrawal**: See DSM-5 definition/criteria on page 11.
- **Withdrawal management (also called detoxification)**: Safe management of intoxication states and of withdrawal.
- **Unhealthy use**: Use that increases the risk or likelihood for health consequences or has already led to health consequences.

Characteristics of addiction
The characteristics of addiction from ASAM’s definition of addiction are:

A. Inability to Abstain
B. Impairment in Behavioral control
C. Craving; or increased “hunger” for drugs or rewarding experiences
D. Diminished recognition of significant problems with one’s behaviors and interpersonal relationships
E. A dysfunctional Emotional response

TERMINOLOGY TO AVOID
According to ASAM, the following terminology should be avoided in clinical context:

- **Abuse or substance abuse** (can be pejorative)
- **Inappropriate use** (unclear meaning, pejorative)
- **Misuse** (unclear meaning)
- **Moderate drinking** (implies safety, restraint, avoidance of excess, and health)
- **Problem drinking** (unclear meaning)
- **Problem use** (unhelpful connotations, pejorative)
- **Substance dependence** (confusion between this term and physical dependence)

These terms, while potentially problematic for the reasons implied above, are nevertheless used in this CPM because they have been part of the diagnostic terminology and are commonly used in research.
DSM-5 WITHDRAWAL SYMPTOMS

- **Alcohol**: autonomic hyperactivity; increased hand tremor; insomnia; nausea or vomiting; hallucinations or illusions; psychomotor agitation; anxiety; tonic-clonic seizures
- **Cannabis**: irritability, anger, or aggression; nervousness or anxiety; sleep difficulty; decreased appetite/weight loss; restlessness; abdominal pain, shakiness/tremors, sweating, fever, chills, or headache
- **Opioids**: dysphoric mood; nausea or vomiting; muscle aches; runny nose; pupillary dilation, goose bumps, or sweating; diarrhea; yawning; fever; insomnia
- **Sedatives, hypnotics, or anxiolytics**: autonomic hyperactivity; hand tremor; insomnia; nausea or vomiting; hallucinations or illusions; psychomotor agitation; anxiety; tonic-clonic seizures
- **Stimulants**: fatigue; vivid dreams; insomnia or hypersomnia; increased appetite; psychomotor retardation or agitation
- **Tobacco**: insomnia, irritability, frustration, or anger; anxiety; difficulty concentrating; increased appetite, restlessness; depressed mood

**Diagnostic Criteria**

DSM-IV had identified two levels of substance use disorders, **abuse** and **dependence**. The current DSM-5 gives diagnostic criteria for three levels: **mild**, **moderate**, and **severe** substance use disorder. Table 1 below lists DSM-5 diagnoses with corresponding ICD-10 codes for several SUDs.

**SUD characteristics**

For the use disorders listed in table 1, diagnosis can be made on the basis of ≥ 2 of the following characteristics of impairment or distress for ≥ 12 months, as follows:

- Taking in **larger amounts** than intended
- **Desire** to control use or **failed attempts** to control use
- **Significant time** spent obtaining, using, or recovering from the substance
- **Craving** for the substance
- **Obligation failure** (work, school, home, etc.)
- **Social and interpersonal problems**
- **Activities** (social, occupational, recreational) given up or reduced
- **Physically hazardous** use (e.g., driving, swimming, etc., while under the influence)
- **Physical or psychological problems** likely caused by use
- **Tolerance** (increased amounts needed, diminished effect of substance)
- **Withdrawal** (withdrawal symptoms/substance taken to avoid withdrawal symptoms). DSM defines withdrawal as 2 or more symptoms present between a few hours to a few days of substance cessation or reduction. **The sidebar at left describes the applicable symptoms for each substance type.**

### TABLE 1: DSM-5 diagnoses with ICD-10 codes

<table>
<thead>
<tr>
<th>DSM-5 DIAGNOSIS</th>
<th>MILD DISORDER: 2–3 symptoms present</th>
<th>MODERATE DISORDER: 4–5 symptoms present</th>
<th>SEVERE DISORDER: ≥ 6 symptoms present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use Disorder</td>
<td>ICD-10: F10.10</td>
<td>ICD-10: F10.20</td>
<td>ICD-10: F10.20</td>
</tr>
<tr>
<td>Inhaling Use Disorder</td>
<td>ICD-10: F18.10</td>
<td>ICD-10: F18.20</td>
<td>ICD-10: F18.20</td>
</tr>
<tr>
<td>Sedative, Hypnotic, or Anxiolytic Use Disorder</td>
<td>ICD-10: F13.10</td>
<td>ICD-10: F13.20</td>
<td>ICD-10: F13.20</td>
</tr>
<tr>
<td>Tobacco Use Disorder</td>
<td>ICD-10: Z72.10</td>
<td>ICD-10: F17.200</td>
<td>ICD-10: F17.200</td>
</tr>
<tr>
<td>Other Hallucinogen Use Disorder</td>
<td>ICD-10: F16.10</td>
<td>ICD-10: F16.20</td>
<td>ICD-10: F16.20</td>
</tr>
<tr>
<td>Opioid Use Disorder</td>
<td>ICD-10: F11.10</td>
<td>ICD-10: F11.20</td>
<td>ICD-10: F11.20</td>
</tr>
<tr>
<td>Stimulant Use Disorder (amphetamine-type)</td>
<td>ICD-10: F15.10</td>
<td>ICD-10: F15.20</td>
<td>ICD-10: F15.20</td>
</tr>
</tbody>
</table>
KEY RECOMMENDATIONS

- Know the short- and long-term risks associated with marijuana — and communicate these to patients and families.
- Carefully consider the use patterns of patients with prescriptions for opioids, benzodiazepines, or other drugs of potential abuse. Be alert to red flags for abuse and diversion.
- Smoking may be associated with other psychiatric disorders and can further negatively impact health outcomes.
- E-cigarettes smoking is potentially harmful and may lead to traditional tobacco use.
- Alcohol overconsumption, including “binge drinking,” leads to both short- and long-term negative health outcomes...

ABOUT URINE DRUG TESTING

- Current drug screening tests aren’t 100% reliable, but can be clinically useful.
- Screening is recommended for all patients:
  - When there is any suspicion/admission of substance use (to guide clinical decisions)
  - Who are referred to inpatient care
  - Who engage in risky behavior
- Screening should also be done when an adolescent is suicidal.
- The types of screens used routinely in clinical care include:
  - Point-of-care screens that are usually done in the office
  - A Drug of Abuse (DRUGU) screen done in the hospital (all DRUGU screen positive results prompt confirmatory testing)
  - For more information, refer to page 10 of the Prescribing Opioids for Chronic Non-cancer Pain CPM.

SUBSTANCE-SPECIFIC CONSIDERATIONS

This section discusses common concerns related to specific substances that affect patient care: changing attitudes and new research about use and abuse,

Marijuana: Key considerations

As marijuana laws have been liberalized in many states, public perception of use has become more favorable as a harmless pleasure (or, as in the case of medical marijuana, a completely safe therapeutic agent). As a healthcare organization, Intermountain focuses on marijuana’s largely negative impact on health and wellbeing — and on our responsibility to educate and treat patients according to research-based recommendations. Key points to emphasize with our patients and families are:

- **Short-term use has a range of adverse effects.** Marijuana impairs judgment, short-term memory, and coordination; a person under its influence has increased difficulty learning and is at risk for dangerous behaviors (especially risky sexual behavior and poor driving). Marijuana is the illicit drug most frequently reported in connection with impaired driving and crashes — including fatal accidents.

- **Long-term and heavy use is linked to serious individual and societal harm.** Adverse effects include cognitive impairment, increased risk of mental health disorders (ranging from depression to psychosis), and respiratory and cardiovascular problems. Long-term users have poor educational outcomes, diminished life satisfaction, and lower achievement as compared to the general population.

- **Use by those under the age of 25 is particularly worrisome.** This age group is at high risk for altered brain development as well as lower achievement and satisfaction.

- **Marijuana is addictive.** Marijuana is the most commonly used “illicit” drug in the U.S. — and approximately 9% of people who experiment with marijuana will become addicted. One in six people who begin using marijuana in adolescence become addicted. Among people who use marijuana heavily, as many as 50% meet the criteria for cannabis use disorder.

- **More research is needed to demonstrate medicinal effects.**

Prescription medications: Recognizing signs of abuse or diversion

Prescription pain medication addiction, abuse, and diversion have increased dramatically in the past two decades. In the U.S. in 2009, nonmedical use of pain relievers was a leading form of drug abuse for people aged 12 or older, second only to marijuana. It is important — but sometimes challenging — to distinguish addiction from other conditions and problems that can occur in the context of long-term opioid therapy; wide variety in prescribing rates for opioids and benzodiazepines can further confound efforts to identify “normal” use. Refer to the Prescribing Opioids for Chronic Non-cancer Pain CPM or CDC Prescribing Guidelines.

Considerations for providers: Is it abuse?

As you use the tools in this CPM with patients who are prescribed opioids or other drugs of potential abuse, bear in mind these distinctions from the American Academy of Pain Medicine, American Pain Society, and the American Society of Addiction Medicine:

- **Addiction** is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It’s characterized by at least one of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

- **Physical dependence** is manifested by a withdrawal syndrome specific to a drug class; it can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

- **Tolerance** is a physical adaptation to a drug: greater amounts are required over time to achieve the initial effect as the body “gets used to” and adapts to the intake.
**OPIOID RED FLAGS**

In patients undergoing treatment with medications of potential abuse, be alert to the following:

The patient:
- ☐ Appears sedated, confused, intoxicated, or exhibits withdrawal symptoms (page 11).
- ☐ Requests more frequent refills and with a sense of urgency. May claim that their medications were “lost.”
- ☐ May share unusual common factors with other patients who come to the clinic on the same day to request controlled substance prescriptions.
- ☐ Resists changes in therapy despite clear evidence of adverse effects; wants to direct their own care.
- ☐ Implies or makes direct threats to the prescriber or staff.
- ☐ Refuses to sign a MMA or is non-compliant with the MMA.
- ☐ Alters, forges or rewrites prescriptions.
- ☐ Requests specific drug combinations.
- ☐ Repeatedly seeks medications from ED.
- ☐ Suffers overdose or frequent injuries and accidents.
- ☐ Shows signs of skin tracks or scars.
- ☐ The PDMP suggests evidence of “doctor shopping or use of multiple pharmacies to acquire controlled substance prescriptions;” may “bad mouth” other MDs.
- ☐ Urine drug screens are inconsistent.
- ☐ Family and/or friends report suspected diversion activities.

**NOTE:** Extra precautions should be taken to secure opioid medications when children and adolescents are present in the household.

- **Pseudoaddiction** is a term sometimes used to describe patient behaviors that may occur when pain is under treated. Patients with unrelieved pain may become focused on obtaining medications, may “clock watch,” and may otherwise seem inappropriately “drug seeking.” Even illicit drug use and deception can occur in the patient’s efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

The sidebar at left presents discerning red flags of abuse or diversion — the presence of drugs of abuse, high doses of prescribed medications, and/or multiple medication prescribers — as well as validated risk assessment tools for use prior to prescribing opioids to all patients, whether opiate naïve or veteran users.

**Naloxone:** Dealing with opioid overdose

Opioid overdose is currently the leading cause of injury death in Utah. Naloxone hydrochloride is an emergency opioid antagonist that is FDA-approved for the treatment of opioid overdose. Naloxone is NOT a controlled substance and can be prescribed without liability. According to 2016 Utah Code, naloxone can be prescribed to any individual at risk of opioid overdose, to a family member, friend, or other person in a position to assist an individual who is or may be at risk, or to an outreach provider. Intermountain community and other pharmacies have collaborative agreements in place that allow patients to obtain naloxone without a prescription. For more information, refer to the clinical guideline, *Clinical Recommendations for Prescribing Naloxone*.

**Smoking:** Consider it in context

More than 40% of the cigarettes smoked in this country are smoked by individuals with a psychiatric disorder, such as major depressive disorder, alcoholism, post-traumatic stress disorder (PTSD), schizophrenia, or bipolar disorder. Smoking by patients with mental illness contributes greatly to their increased morbidity and mortality.

**What you need to know about e-cigarettes**

- E-cigarettes are devices that turn nicotine, flavorings, and other chemicals into vapor that you inhale (smoke or “vape”). E-cigarettes are tobacco products.
- Many e-cigarettes look like regular cigarettes. Others look like everyday objects like pens or small flashlights. They come in a variety of colors, and the vapor comes in different flavors (e.g., grape, gummy bear, and tutti-frutti). E-cigarette marketing aggressively targets children and teens.
- E-cigarettes are often marketed as the “safe alternative” to smoking. However, experts agree that they’re potentially harmful.
- The WHO has called for a ban on indoor e-cigarette use (this is already Utah law) and stronger regulations to keep minors from using the devices.

A recent policy statement from the American Heart Association urges stronger FDA regulation of e-cigarettes and expresses concern that they may be a gateway to traditional tobacco products.

**Alcohol:** New evidence of a serious drinking problem

Based on the 2014 National Health Interview Survey, the percent of adults 18 years and over who had at least one heavy drinking day (five or more drinks for men and four or more drinks for women) in the past year was 24.9% with men more likely than women to have had at least one heavy drinking day in the past year.

Other research published in 2014 found that excessive drinking was the cause of one in 10 deaths among working-age adults between 2006 and 2010. Excessive drinking activities were defined to include, “...binge drinking, heavy weekly alcohol consumption, and drinking while under age or pregnant.” Researchers found that these activities instigated, “...long-term health effects such as liver disease and heart disease, as well as short-period effects such as violence, alcohol poisoning, car crashes, and drowning.”
SPECIAL POPULATIONS

This section addresses special risks for particular patient populations and the complexity of SUD in the context of treatment for chronic conditions.

SUD is found in every segment of the population. The populations discussed below are at increased risk for SUD or have special risks associated with substance use.

Adolescents

Adolescence is the critical period for the initiation of substance use, and the high rate of teen substance use has prompted the National Center on Addiction and Substance Abuse (CASA) to call it “America’s #1 Health Problem.” Assessing and treating SUD in adolescents should be a major focus of medical care — and providers should be prepared to confront its particular challenges. Refer to the screening algorithm on page 6 and to the Guidelines for Adolescent Alcohol and Drug Use Interventions.

Key considerations for evaluating adolescent substance use include:

- **It can be difficult to distinguish between experimentation and use** (for both provider and patient). Use recommended screening and assessment tools, share results with the patient, and educate/refer based on the algorithms in this CPM.
- **Adolescent users differ from adults in many ways.** Their drug and alcohol use often stems from different causes, and they have even more trouble projecting the consequences of use into the future. To promote behavior change, note and address the patient’s motivational barriers.
- **Adolescent use presents unique (and uniquely serious) risks.** Patients and families should be advised that the impacts of substance use in adolescence include:
  - Permanent alterations to normal brain development: impaired cognition, stunted emotional growth, and compromised social development occur because the adolescent brain is still developing.
  - A sharp increase in the chance of addiction: A recent national study found that one in four Americans who began using any addictive substance before age 18 are addicted, compared to one in 25 Americans who started using at age 21 or older.
  - Poor educational and employment outcomes: Fewer job prospects and reduced life satisfaction are strongly associated with adolescent use.
  - Immediate consequences of substance use that are often more severe in immature and inexperienced adolescents: Risks from impaired judgment — poor driving, risky sexual behavior — may be highest. At a physical level, adolescents tend to have smaller body sizes and lower tolerances, putting them at high risk for problems, even at low levels of consumption.
- **Interventions must involve both patient and family.** Parents often feel frustrated and powerless; providers should seek to help manage expectations and should refer to family counseling as appropriate.

College-age adults

A recent national survey found that almost half of college-aged adults (ages 18 to 24) meet criteria for substance use disorder, personality disorders, or another mental health condition during a one-year period, but only one-fourth of those seek treatment. Although overall rates were similar among those attending college than those not attending college, college students were significantly less likely to receive treatment for alcohol or drug use disorders than those not in college.
OPIOID USE IN PREGNANCY

Coordinate with the obstetrical provider to manage per the following recommendations.

If the patient is on short-acting prescription opioids (hydrocodone, oxycodone) and is motivated to stop/decrease use, attempt to wean on an outpatient basis: decrease dose 10% – 15% weekly while engaging patient in ongoing SUD treatment (see page 8). If the patient is on methadone or buprenorphine, continue therapy on an outpatient basis throughout the pregnancy. For all other patients using opioids, carefully transition to buprenorphine or methadone as follows.

* When considering these medications, ENSURE CONTINUED MANAGEMENT with follow up by a physician licensed to prescribe Subutex or by referral to a federally funded methadone clinic. Experienced providers and specialty clinics can monitor dose increases likely needed in the third trimester.

* ADMIT patient and OFFER PATIENT THE CHOICE of buprenorphine or methadone considering the following advantages:

  - **Buprenorphine:** generally the preferred agent for use in pregnancy (excluding Suboxone, which contains naloxone and is not recommended in pregnancy). May lower chance/severity of neonatal abstinence syndrome (NAS) in the infant and decrease LOS. Maintenance therapy will not require daily, early-morning visits to a methadone clinic. Is generally safer as it lacks methadone’s usual risks (e.g., respiratory depression if methadone builds up over time).

  - **Methadone:** May be preferred for women who are either on very high doses of opioids and may not respond well to buprenorphine or who are concerned about its risk for precipitating withdrawal.

* MANAGE the transition.

  - **If buprenorphine:** Loading buprenorphine for subjective withdrawals 2 – 4 mg every 2 – 4 hours may be preferred to a COWS protocol. Start with the usual 2 mg test dose, and reevaluate in 1 hour to ensure drug tolerance (not inducing withdrawal). If withdrawal symptoms, load 2 – 4 mg every 2 – 4 hours, and titrate per symptoms.

  - **If methadone:** Give initial dose, generally 10 – 20 mg with an additional 5 mg every 4 hours as needed for ongoing withdrawal symptoms (total MUST NOT exceed 40 mg on day 1). On day 2, initial dose should equal the total dose given on day 1, adding 5 mg every 4 hours as needed for symptoms (the PRN dose should not exceed 10 mg). On day 3 and after, continue this pattern (previous day’s total, plus 5 mg PRN every 4 hours with PRN dose not to exceed 10 mg) until the total from day to day is equivalent; this is the stable dose for this patient.

  - **Consider potential risks of managing anxiety that accompanies withdrawal for either drug.** Although, many clinicians use clonidine, benzodiazepines, or methocarbamol (Robaxin), their use is controversial. While these agents may be helpful, they may cause increased respiratory depression and mask withdrawal and thus the need for more opioid replacement. Finally, because benzodiazepine use beyond discharge increases the risk of relapse, we recommend NOT discharging patients with benzodiazepine prescriptions.

Authors of the report analyzing data from the National Epidemiologic Survey on Alcohol and Related Conditions note that young adults are at a vulnerable stage of development, and conclude, “The vast majority of disorders in this population can be effectively treated with evidence-based psychosocial and pharmacological approaches…. Early treatment could reduce the persistence of these disorders and their associated functional impairment, loss of productivity, and increased health care costs.”[JAM1]

Pregnant women

Compared to other states surveyed between 2000 and 2007, Utah has the highest rate of opioid use in pregnancy: more than 41 % of Utah women on Medicaid filled a prescription for opioids during their pregnancies.[DES] As opioid use has grown locally, Intermountain data suggest that chronic use of opioids among pregnant women has resulted in more NICU admissions for neonatal abstinence syndrome (NAS) and an increased length of stay (LOS) for newborns.

To care for pregnant patients, Intermountain’s CPM, Assessment and Management of Opioid Use in Pregnancy, provides the following guidance:

* Screen and educate every pregnant patient.[ACOG] Abuse is common and often overlooked—even by patients. Obstetric care providers should screen at every encounter or at least once every trimester of pregnancy. Regardless of screening results, providers should also educate these patients:

  - Ask patients what they know about substance use during pregnancy; then, fill in as needed.[VER]

  - Make sure patients understand that prescription medication—not just “street drugs”—can be misused and present risk.

* If the patient uses opioids, attempt to coordinate management through team-based care involving the patient’s obstetric care provider, primary care physician, opioid prescriber, and if needed, a substance use disorder professional. With guidance from the team and with the patient and her family/support system, develop a plan to care for her and her baby during pregnancy and after delivery.

Follow up to manage and coordinate this aspect of patient’s care; refer for counseling and treatment as needed. Treatment for substance use disorder during pregnancy can be more effective than at other times in a woman’s life.[VER] Women who receive treatment early in their pregnancy can achieve the same health outcomes as pregnant women without substance use.

CARE PROCESS MODEL (CPM)

Intermountain’s Management of Opioid Use in Pregnancy CPM provides guidance on screening and caring for women using opioids during pregnancy.
People with eating disorders

SUD is frequently comorbid with eating disorders, especially anorexia nervosa and bulimia nervosa. A large-scale report from CASA found that people with eating disorders were up to five times as likely as those without eating disorders to abuse alcohol or illicit drugs, and those who abused alcohol or illicit drugs were up to 11 times as likely as those who did not to have had eating disorders. 

Intermountain’s care recommendations for patients with eating disorders are summarized in the care process model Management of Eating Disorders; recommendations are situated in a multidisciplinary, stepped-care approach that is compatible with the team-based levels of care outlined in this CPM.

Military

The National Institutes of Health report that although illicit drug use is lower among U.S. military personnel than among civilians, heavy alcohol and tobacco use — and especially prescription drug abuse — are much more prevalent and are on the rise. Service members with multiple deployments and combat exposure are at greatest risk of developing substance use problems. Department of Defense (DoD) surveys found that:

- In 2008, 11% of service members reported misusing prescription drugs, up from 2% in 2002 and 4% in 2005. Most of the prescription drugs misused by service members are opioid pain medications.
- Almost half of active duty service members (47%) reported binge drinking in 2008 — up from 35% in 1998.
- In 2008, the suicide rate among service members surpassed the civilian rate for the first time — with substance use estimated to be involved in almost one-third of suicides.

Identifying and treating SUD among service members can be a challenge; zero-tolerance policies, social stigma, and lack of confidentiality deter many who need treatment from seeking it.

The Institute of Medicine (IOM) notes that service members, especially those returning from deployment, frequently have concurrent pain, emotional, and substance use problems — and that team-based primary care is well-positioned to care for the whole patient with this complex of issues. The IOM’s recommendations for physicians who care for service members aligns with the evidence-based recommendations in this CPM.

Elderly

SUD among people age 65 or older has been called a hidden national epidemic. Some key statistics:

- While an estimated 10% of the U.S. population abuses alcohol, recent surveys reveal that as many as 17% of elderly adults have an alcohol-abuse problem.
- Americans age 65 and older make up 13% of the population but consume about one-third of all prescription drugs. Older individuals also take more potentially addictive medications than any other age group.

Providers should be aware of the prevalence of SUD in elderly patients, understand that the health consequences for older adults may be particularly grave — and always screen and treat according to the recommendations in this CPM.
KEY RECOMMENDATIONS

- Follow the SBIRT model, with a focus on the brief intervention if an at-risk user is identified.
- Refer to MHI’s team-based, integrated model, which stratifies patients into risk groups and suggests interventions at the appropriate level, with the appropriate provider(s).

MANAGEMENT IN PRIMARY CARE

Management in primary care is modeled after the SBIRT model — Screening, Brief Intervention, and Referral to Treatment. This model is primarily for patients with hazardous, at-risk, or harmful substance use (with severity that doesn’t meet the criteria for a diagnosis of an SUD). It can also be used for patients who meet the diagnostic criteria of SUD; the goal with these patients is to motivate them to go to treatment.

In this model, core interventions are basic motivational interviewing and patient education. After the patient is referred, the PCP may be involved in ongoing care and follow-up, particularly if the patient has comorbidities. (Clinics that have implemented MHI will be familiar with the integration treatment cascade process.)

Lay the foundation to consistently implement SBIRT by first defining roles, responsibilities, and resources for your clinic (see table 2 below). MHI clinics can likely graft the SBIRT model onto existing processes.

<table>
<thead>
<tr>
<th>TABLE 2: Key roles and responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>CRAFFT (ages 12 to 18)</td>
</tr>
<tr>
<td>Administer NIDA Quick Screen (age ≥ 18)</td>
</tr>
<tr>
<td>Administer ASSIST-based Assessment (age ≥ 18)</td>
</tr>
<tr>
<td>Score ASSIST-based Assessment, share results with patient (age ≥ 18)</td>
</tr>
<tr>
<td>Provide brief intervention (all patients)</td>
</tr>
<tr>
<td>Provide patient education materials (all patients)</td>
</tr>
<tr>
<td>Prescribe and update medications (all patients)</td>
</tr>
<tr>
<td>Facilitate referrals (all patients)</td>
</tr>
<tr>
<td>Follow up after brief intervention (all patients)</td>
</tr>
</tbody>
</table>

SBIRT IN ACTION

Some recent studies have cast doubt about the positive impact of brief intervention for reducing problem drug use. Nevertheless, this CPM advocates for the SBIRT model to increase identification (via screening) of all types of substance use, to increase referrals for treatment, and as a step toward clinical consistency and continuous improvement while studies of these interventions continue.
SCRENNING WITH CRAFFT FOR ADOLESCENTS, AGES 12 THROUGH 17

Addiction often starts in adolescence and becomes a lifelong problem. More than 75% of high school students have used addictive substances, and nearly half are current users. Adolescents who use addictive substances are more susceptible to developing addiction and facing a lifetime of substance-related problems. Use the algorithm and CRAFFT tool described on pages 6 through 7 for screening adolescents for drug and alcohol use.

GOALS OF THE ASSIST

The World Health Organization (WHO) developed the ASSIST to meet several goals:

• Shorten assessment time to facilitate screening in primary care.
• Screen for all psychoactive substances — previous screens included only alcohol or cigarettes.
• Identify patients needing brief intervention.

Adults: Screening with NIDA in those 18 and older

Before administering the NIDA Quick Screen, ask permission of your patient, emphasizing that screening is a routine part of medical care, honest and complete answers are important, and responses will be kept confidential. Remember that with this tool, any positive response means a positive screening result.

Adults: Assessment with the ASSIST for those 18 and older

Intermountain’s clinician-administered assessment tool derives from the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST). Note that the ASSIST is only validated for use in an interview format; further research is needed to determine if it is suitable for self-administration. This section describes the portions of the Intermountain-modified ASSIST-based Assessment tool, how to facilitate the conversation, and how to score the assessment.

The introduction

The ASSIST-based Assessment includes an introduction that can be read or paraphrased. The following needs to be covered during the introduction:

• The Substance Use Response and Report Card for Patients, including the list of substances and common terms used for each substance. (Provide a copy to the patient.)
• The questions cover the last three months and lifetime use.
• The questions are about non-prescribed use only.
• Responses are confidential.
Using the ASSIST-based Assessment tool

The ASSIST-based Assessment includes prompts and instructions that direct you to skip some questions depending on patient responses. The graphic below shows the basic flow.

**VALIDATION OF THE ASSIST**

WHO has conducted three clinical trials to assess the validity of the ASSIST.

- **Phase I:** Assessed the reliability and validity of the initial 12-question version of the ASSIST and resulted in a revision to an 8-question version.

- **Phase II:** Validated the ASSIST in primary care and drug treatment settings, and demonstrated its good concurrent, constructive, predictive, and discriminant validity.

- **Phase III:** Investigated the effectiveness of a 5- to 15-minute brief intervention for patients identified as moderate risk based on the WHO. Patients with moderate risk who received a brief intervention had significantly reduced ASSIST scores three months after the intervention as compared to the control group. In addition, 80% of patients who received the brief intervention reported that they had tried to cut down.

**Scoring the assessment**

To score the ASSIST-based Assessment, add the total scores from questions 2 to 7 for each substance to calculate the risk score for each drug. Then, record the score in the box on the last page.

**Interpreting the score**

The ASSIST-based Assessment score indicates substance-related risk (see table 3 below). However, substance-related problems are complex, and many factors can modify a person’s risk (e.g., family history, mental and physical comorbidities, support). Clinical judgment and additional patient information should be factored into assessing the patient’s risk.

**Completing the Substance Use Response and Report Card for Patients**

The patient’s scores should be written on the Substance Use Response and Report Card for Patients. This provides a page for the patient to take home. The card can support the discussion of the patient’s risk level.

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**TABLE 3: ASSIST-based Assessment risk scores**

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>All other substances</th>
<th>What this score indicates</th>
</tr>
</thead>
</table>
| **Lower risk** | 0–10    | 0–3                  | • Low risk of problems related to substance use.  
• Patient is not currently experiencing problems related to substance use.  
• Risk is relatively low based on current pattern of use. |
| **Moderate risk** | 11–26   | 4–26                 | • Moderate risk for health and other problems; may be experiencing some problems now.  
• If current patterns continue, future health and other problems are likely including dependence. |
| **High risk**   | 27+     | 27+ or Injected drugs ≥ 4 times monthly in last 3 months | • High risk of dependence or current dependence.  
• Probably experiencing health, social, financial, and/or legal problems as a result of substance use. |

---

**Scoring Exception:** If a patient hasn’t used a substance for the past three months but still scores a “6” for that substance, the Assessment places that patient in the moderate risk category where a brief intervention may be inappropriate. The clinician can instead congratulate the patient for ongoing abstinence and offer support as needed.
A LIFETIME PARTNERSHIP

The initial brief intervention is only the beginning of an ongoing, lifelong partnership between you and the patient. Behavior change is a process, and one major goal with these patients is to open the conversation so that when the patient is ready, you’ve established a safe environment for them to come back to.

EXAMPLE STATEMENTS FOR BRIEF INTERVENTION

- Providing personalized feedback to ADULTS (ASSIST score):
  “These are all the substances I asked you about, and these are your scores for each substance (point to scores). As you can see, your score for marijuana was 18, which is also in the moderate risk range. Moderate risk means that you are at risk of health and other problems from your current pattern of substance use, not only now but also in the future if you keep using in the same way.”

- Providing personalized feedback to ADOLESCENTS (CRAFFT score):
  “I am concerned about your drinking. As our doctor, I advise you to stop drinking completely for the sake of your health. Do you think you could stop drinking until our next visit? Would you be willing to try?”

- Sharing information on health effects and risks:
  “Because you’re in the moderate risk range for your use of marijuana, the kinds of things associated with your current pattern of marijuana use are problems with attention and motivation, feeling anxious, panicky or depressed, difficulty solving problems or remembering things, high blood pressure, asthma, bronchitis, and at the serious end of things, psychosis, heart and airways disease, and cancers…”

- Giving advice for reducing risks:
  “The best way you can reduce your risk of these things (harms) happening to you is to either cut down or stop using (substance).”

- Affirming patient responsibility, and asking for their input:
  “How concerned are you by your score for (substance)?”

- Weighing the good and the bad, from the patient’s perspective:
  “What are the good things for you about using (substance)? What are some of the less good things?”

- Asking about the patient’s concerns:
  “Do the less good things concern you? How?”

- Educating the patient, supporting change:
  “People find this handout useful if they’re thinking about whether they want to cut down on their substance use…”

See page 22 for additional resources.

Brief intervention

Brief interventions in primary care take between three and 15 minutes during the initial appointment. In general, for moderate-risk patients, the goal of the brief intervention is to change behavior; for high-risk patients and illicit drug users, the goal is to motivate the patient to participate in treatment and follow through on referrals. (Note: this CPM recommends that drug users at moderate risk also be referred for follow-up.)

Brief interventions can be adapted based on the amount of time you have available. If multiple substances are of concern, the brief intervention should focus on the patient’s main substance (the one with the highest ASSIST-based Assessment risk score).

<table>
<thead>
<tr>
<th>TABLE 4: Steps of the brief intervention</th>
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</thead>
<tbody>
<tr>
<td><strong>If you have…</strong></td>
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<tr>
<td><strong>3–5 minutes</strong></td>
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<td><strong>5–15 minutes</strong></td>
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<tr>
<td>More time</td>
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</tbody>
</table>

Conversation basics: principles for effective intervention

In your interventions, it’s vital to discuss concerns in a way that preserves your alliance with the patient. The perceived stigma associated with SUD can make this difficult. See the suggestions below:

- Remind patients that you screen everyone, that risk assessment is based on solid evidence, and that intervention is a standard part of good medical care.

- Affirm the patient’s privacy. For example, “For us to work together, I need you to be honest about any alcohol or drug use in your life. Your responses will be kept confidential.”

- Present concerns in a direct way, avoiding judgment. Be clear that SUD is a medical, not a moral, condition. (See example statements in the sidebar.)

- Use language that prompts conversation. Techniques include:
  – Inviting elaboration. “Tell me more about that.”
  – Asking open-ended questions. “How is the substance affecting your life?”
  – Summarizing (reflective listening). “What I hear you saying is that…”

- Show empathy. Patients often presume that if they tell their doctor about their substance use, their doctor will be shocked or offended. Avoid communicating disapproval (check your facial expressions, body language, etc.) and express empathy for the patient.

- Affirm the relationship. Where possible and appropriate, don’t abandon the patient. For example, “Your questionnaire tells us you’re at risk, and you’ve also expressed concerns. Let’s figure out how you can make some changes. I’ll continue to work with you to care for your health.”
Engaging patients in the behavior change process: Motivational interviewing and readiness to change

Motivational interviewing is a collaborative method of addressing the common problem of ambivalence toward change. It differs from more coercive methods of encouraging change in that it draws on the patient’s personal values and motivations. It involves:

- Asking open-ended questions to elicit the patient’s concerns and context (work, family, etc.).
- Listening actively and summarizing the patient’s concerns back to them.
- Empathizing and clarifying the patient’s experience without judging, criticizing, or imposing your own values.
- Enlisting the patient in suggesting options, setting goals, and planning details.

Readiness to change: Most patients are ready to change something. The video link at right illustrates how motivational interviewing can be used to help patients identify something they are currently ready to change—and then arrive at ways to do it. If a patient is not ready to address a critical issue, success can be measured by helping the patient move toward readiness. The table below recommends interventions and dialogue to increase a patient’s readiness in relation to a particular concern. If the patient is not ready to change:

- Assess the patient’s current stage of readiness by observing patient comments.
- Consider a brief intervention appropriate to that stage, as described in the table below.
- If the behavior change is critical and the patient is not ready, refer to a care manager or specialist for further motivational interactions with the patient.

| TABLE 5. Assessing and promoting patient readiness for behavior change³¹⁵| |
|---|---|---|---|---|
| **NOT READY** | **UNSURE** | **READY** | |
| **What the PATIENT may think or say:** | | | |
| Patient does not realize the issue is a problem, or is not interested in changing. | Patient is aware of the problem, but may not feel ready or able to change yet. | Patient has decided to change and is thinking about how to do it. | Patient has changed the behavior but may relapse. |
| “I can’t even think about changing that right now.” | “I know I should do this. My spouse wants me to do it.” | “I’ve been thinking more about making this change.” | “I’m doing it. I really messed up, but I started again the next day.” |
| **Possible PROVIDER interventions and dialogue to help move patients forward on the readiness scale:** | | | |
| Help patient start to think about change. | Help patient resolve ambivalence and find internal motivations. | Help and troubleshoot barriers and increase self-efficacy related to this change. | Help build skills in self-monitoring, stimulus control, and problem solving. |
| “What change could you consider right now?” | “Can I give you more information about how this change could benefit you?” | “What might make you feel more ready or able?” | “Great. Let’s discuss the details of your plan.” |
| | “You know, you don’t have to go this alone. Would it help to hear about some possible sources of support?” | “Should we review some options for support?” | “Let’s figure out how we can stay in touch as you go forward. We can see this through together.” |
| | | | “Great job. What helped you get back on track?” |
Patient education materials to support SBIRT

Written materials can support your efforts to educate patients and engage them to change behavior. They don’t replace direct, personal contact with PCPs in the clinic, but rather complement and reinforce these interventions by providing a means for patients to reflect and learn in another mode and at their own pace.

Table 6 below identifies Intermountain materials recommended for supporting SUD interventions in primary care. Note that materials cover many general and substance-specific topics and are sometimes aimed at particular audiences (e.g., teens, parents). To access these materials:

- Log in to intermountainphysician.org. Search for the patient education library under A–Z. Then, search the item number and title in the appropriate area.
- Use iprintstore.org, Intermountain’s Online Library and Print Store, for one-stop access and ordering for all Intermountain materials (fact sheets, booklets, trackers, etc.): iprintstore.org. If you need any assistance, email printservices@imail.org.
- As the iCentra EMR system is implemented, search for Intermountain items in the patient education module.

For additional topics, access the third-party items listed at left (links are underlined).

**Table 6: Recommended patient and family education for brief interventions**

<table>
<thead>
<tr>
<th>Intermountain Education item</th>
<th>Notes on content, use</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSLW023 Well Check: Young Adult</td>
<td>For adolescents, tips for staying healthy, being safe, and handling relationships and stress.</td>
</tr>
<tr>
<td>FS417 Substance Use: Plan to Cope with Triggers</td>
<td>GIVE THIS IF PATIENT IS POSITIVE on ASSIST for ANYTHING and expresses desire to change behavior</td>
</tr>
<tr>
<td>FS416 Alcohol: Rethink Your Drink OR RETHINKING DRINKING: Alcohol and Your Health (National Institute of Health), order copies from pubs.niaaa.nih.gov</td>
<td>For all ages; handout; explains standard drink sizes and how alcohol risk levels (general, NIH) are assessed, lists health risks</td>
</tr>
<tr>
<td>FS433 Opioids: Understanding the Risks</td>
<td>GIVE THIS IF PATIENT IS POSITIVE on ASSIST for OPIOIDS</td>
</tr>
<tr>
<td>FS474 Naloxone for Opioid Overdose</td>
<td>GIVE TO PATIENTS WHO MAY EITHER BE AT RISK OR MAY BE CLOSE TO SOMEONE AT RISK FOR OPIOID OVERDOSE OR ANY PATIENT RECEIVING OPIOID-SPECIFIC EDUCATION.</td>
</tr>
<tr>
<td>FS395 Prescription Pain Medication in Pregnancy</td>
<td>For pregnant women; handout; explains risks of use to mother and child and stresses importance of working with provider</td>
</tr>
<tr>
<td>FS194 Leftover Medications: How to Dispose of Them Safely</td>
<td>EXPLAINS DANGERS OF KEEPING LEFTOVER MEDICATION AND GIVES TIPS FOR PROPER DISPOSAL</td>
</tr>
<tr>
<td>SMK001 Quitting Tobacco: Your Journey to Freedom</td>
<td>For all ages; booklet; comprehensive health information and quit strategy, includes Intermountain-recommended resources and references</td>
</tr>
<tr>
<td>FS421 E-Cigarettes: Questions and Answers</td>
<td>GIVE THIS IF PATIENT IS POSITIVE on ASSIST for TOBACCO USE</td>
</tr>
<tr>
<td>FS369 Secondhand Smoke and Your Child’s Health</td>
<td>GIVE THIS IF PATIENT IS POSITIVE on ASSIST for E-CIGARETTE USE</td>
</tr>
<tr>
<td>FS432 Sedatives and Sleeping Pills: Understanding the Risks</td>
<td>GIVE THIS IF PATIENT IS POSITIVE on ASSIST for SEDATIVES AND SLEEPING PILLS</td>
</tr>
</tbody>
</table>
FACILITATE A WARM HAND OFF
Whenever possible, make a personal and direct referral to help the patient overcome any barriers to treatment. This “warm hand off” may include a conference phone call to introduce the patient to the specialist, an offer to make the appointment now, or a suggestion to have your MA walk the patient to the next clinic—anything that builds on your alliance with the patient and uses a personal connection to facilitate the patient’s entry to treatment. Some tips for making your referral:

- Make your referral to SUD treatment as direct as you would a referral to any other service. Since your patients will take their cue from you, let the tone and content of your referral convey that treatment is an important part of normal medical care.
- Unless your patient has used a diagnostic term on him or herself (“I feel anxious”; “I’m addicted”), refer to behavioral health problems in general terms like “stress.” In treatment, the specialist can work with the patient to identify and address the issues at play in the patient’s pattern of use.
- Use general terms such as “colleague” or “someone who specializes” instead of “counselor,” “therapist,” or “social worker”—and talk about the patient obtaining “education,” “ideas,” and “support,” rather than “counseling.” These terms are less likely to invoke the stigma associated with behavioral health treatment.

ADULT SELF-HELP GROUPS
For adults, research has shown that participation in self-help groups such as Alcoholics Anonymous improves substance use outcomes (lowered use and increased abstinence). Self-help groups are often used in conjunction with specialty treatment: almost 33% of those who attended self-help groups for substance use also received specialty treatment for substance use in the past year. People often continue to participate in self-help groups beyond treatment as they go through the recovery process.

Intermountain recommends encouraging adult patients to participate in self-help groups at any treatment stage. They are widely available, include treatment of nearly every type of substance use (e.g., Cocaine Anonymous, Marijuana Anonymous, Methadone Anonymous, Narcotics Anonymous, Nicotine Anonymous), and are available for family members (e.g., Al-Anon, Alateen, Nar-Anon).

Find local meetings via aa.org (Alcoholics Anonymous), na.org (Narcotics Anonymous), al-anon.org (Al-anon and Alateen family support groups).

Referral to treatment
In general, providers should aim to treat in the least-restrictive setting appropriate to the patient’s needs. The goals of referral are to motivate the patient to enter treatment and connect them with convenient, accessible specialty treatment programs.

Provide information in the medical record or referral
When referring, ensure that the following are in the medical record or referral:

- Diagnoses
- Physical and mental health symptoms
- Initial screening scores
- Interventions undertaken
- Referrals made
- Follow-up screening scores/outcomes and treatment utilization
- Next scheduled appointment

Provide a patient summary and patient education
This may be your only opportunity to motivate the patient to seek treatment. Provide a printed copy of the Patient Summary from the iCentra EMR. The Patient Summary includes four default fields: Problem, Medications, Allergies, and Plan of Care. In the Plan of Care, include the following:

- Name, phone number, and address of referral contacts
- Appointment times for follow-up appointments
- Directions for specific services and initial duration and quantity for each service

Also provide patient education (see specific recommendations on page 22). Patient fact sheets include links to various help lines, websites, and other resources (e.g., SAMHSA and NAMI). During referral, you may want to point out these resources; they may be helpful for your patient now or in the future.

Where to refer?
Refer based on the patient’s severity, insurance, and other factors. Treatment programs include (see pages 25–27 for available specialty treatment level descriptions):

- FOR ADULTS:
  - Self-help community support programs (e.g., AA, Al-Anon programs) (see sidebar)
  - MHI (for further assessment and treatment of moderate-risk patients)
  - Dayspring Chemical Dependency Program at LDS Hospital (adults only)
  - Specialty psychiatric clinics
  - Emergency departments

- FOR ADOLESCENTS:
  - Primary Children’s program at Wasatch Canyons Behavioral Health Campus
  - McKay-Dee Hospital program at Summit Day Treatment

To find treatment centers, use:

- SAMHSA’s Utah Resource Guide: https://findtreatment.samhsa.gov/locator/home
- The Agape Center website, which lists treatment centers in Utah: theagapecenter.com/Treatment-Centers/Utah.htm
- State of Utah Division of Substance Abuse and Mental Health’s website: dsamh.utah.gov/substance-use-disorders

Follow up
Follow up with the patient in a few days to ensure that care plan compliance. Encourage the patient to call you in the future and (as needed and desired) to include you in any permissions to share treatment information.
Treatment in primary care

All patients with an SUD diagnosis and with moderate risk substance use need ongoing primary care treatment. In general, PCPs should stay involved to treat comorbidities and monitor overall health. However, note that if a patient is admitted to a treatment center, she or he will have to specify in writing, on the PHI release consent form, that the PCP is authorized to access patient information on SUD treatment. See page 30 for more information on patient privacy protections.

Withdrawal management in primary care

If an SUD is suspected, refer for treatment. For patients using alcohol, opioids, or benzodiazepines in excess, managed withdrawal in primary care may be attempted following the guidelines in the table below and in combination with specialty treatment (see pages 25–27).

Uncomplicated alcohol withdrawal can be treated in a primary care setting, but sustained sobriety is unlikely with detoxification alone. Patients should also be actively involved in a program that may include individual and/or group psychotherapy, 12-step/support meetings, and relapse prevention medication such as naltrexone or acamprosate. (See “Specialty Treatment,” pages 25–27.)

<table>
<thead>
<tr>
<th>TABLE 7. Withdrawal management in primary care</th>
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<tbody>
<tr>
<td>Medication</td>
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<tr>
<td>------------</td>
</tr>
<tr>
<td><strong>Alcohol withdrawal — first-line</strong>&lt;sup&gt;APA, BAB&lt;/sup&gt;</td>
</tr>
<tr>
<td>clordiazepoxide (Librium)</td>
</tr>
<tr>
<td>lorazepam (Ativan)</td>
</tr>
<tr>
<td><strong>Alcohol withdrawal — second-line</strong>&lt;sup&gt;APA, BAB&lt;/sup&gt;</td>
</tr>
<tr>
<td>carbamazepine (Tegretol)</td>
</tr>
<tr>
<td><strong>Opioids</strong></td>
</tr>
<tr>
<td>Varies (taper patient’s current opioid)</td>
</tr>
<tr>
<td><strong>Benzodiazepines</strong></td>
</tr>
<tr>
<td>clordiazepoxide HCI (Librium) (preferred)</td>
</tr>
<tr>
<td>clonazepam (Klonopin)</td>
</tr>
</tbody>
</table>
**KEY RECOMMENDATIONS**

- Aim to treat in the least restrictive setting appropriate while still meeting the patient’s needs.
- As supplement and follow up to specialty SUD treatment, encourage adult patients and families to attend self-help groups such as Alcoholics Anonymous, Narcotics Anonymous, or Al-Anon.

**PROGRAM GOALS AND LONG-TERM OPPORTUNITIES**

- **Our goals.** This comprehensive continuum of care will promote patient engagement, individualize care, and provide the appropriate level of care. The ultimate goal is to help the patient successfully reside in the community with his or her family.

  All services are based on individual clinical and medical necessity, in which the team provides access to a comprehensive continuum of services to promote increased functionality and realize goals for resilience and recovery. All services and referral of services will be based on an ongoing assessment.

- **Long-term opportunities.** The Behavioral Health Clinical Program is assessing other opportunities for treatment programs or partnerships and will update this CPM as additional resources are established.

**SPECIALTY TREATMENT**

Intermountain Healthcare is currently developing its SUD treatment programs across the system. The goal is to have a Dayspring Chemical Dependency Program in each region that provides or facilitates access to a comprehensive continuum of care to include Outpatient Services (ASAM level 1), Intensive Outpatient Services (ASAM 2.1), Partial Hospitalization Services (ASAM 2.5), Residential Services (ASAM 3.1–3.5), and Inpatient Services (ASAM 3.7–4).

The following core treatment modalities reflect the standard of care Intermountain plans to establish in each region:

- **Individual, Group and/or Family Treatment:** Addresses diverse patient needs within a full care continuum as outlined in the ASAM Criteria, which ensures that services delivered are individualized, clinically driven, patient directed, and outcome-informed.

- **Medication-assisted Treatment (MAT):** Used for many patients regardless of service level. Historically, many programs thought that abstinence from all substances and psychoactive medications was critical to long-term sobriety. New research supports the use of multiple medications (e.g., Suboxone) in management of withdrawal, psychiatric conditions, and long-term opiate dependence conditions.

See page 27 for a full list of treatment modalities.

**Level 1: Outpatient Services (<9 hours/week adults, <6 hours/week adolescents)**

- **Service components include:**
  - **Individualized biopsychosocial assessment:** Comprehensive substance use and addictive disorder history; physical examination as determined by patient’s medical condition and problems, needs, strengths, skills; and priority formulation to be used in creating an individualized treatment plan.
  - **Skilled treatment services:** Individual and group counseling, motivational interview, enhancement, and engagement strategies, medication management, educational groups, occupational and recreational therapy, psychotherapy, addiction pharmacotherapy, or other therapies. Services provided in an amount, frequency, and intensity appropriate to the patient’s multidimensional severity and functioning level.
  - (For patients with mental health conditions) Addressing (as needed) psychotropic medications and mental health treatment and their relationship to substance use and addictive disorders.

- **Time frames:** Treatment for up to nine hours (adults) or up to six hours (adolescents), based on medical necessity; duration varies with illness severity and treatment response.

- **Team members:** Licensed independent practitioner (LIP) (psychiatrist and/or APRN), recreational therapists, psychologists, licensed mental health therapists (LMHTs), substance use disorder counselors (SUDCs), and registered nurses (RNs).

**Level 2.1: Intensive Outpatient (≥9 hours/week adults, ≥6 hours/week adolescents)**

- **Service components include:**
  - **Individualized biopsychosocial assessment:** Comprehensive substance use and addictive disorder history; physical examination as determined by patient’s medical condition and problems, needs, strengths, skills; and priority formulation to be used in creating an individualized treatment plan.
  - **Skilled treatment services:** Individual and group counseling (motivational interviewing, enhancement, and engagement strategies), medication management, educational groups, occupational and recreational therapy, and other therapies. Services provided in the amount, frequency, and intensity appropriate to treatment plan objectives.
  - **Family therapy:** Involves family members, guardians, or significant others in the assessment, treatment, and continuing care of the patient.
  - **Planned therapy format:** Delivered on an individual and group basis and adapted to the patient’s developmental stage and comprehension level.
GUIDING TREATMENT PRINCIPLES AND BELIEFS

- Healing and recovery are possible. We believe in the patients and view them as capable and competent. We deliver services with an attitude of hope.

- The patient/provider relationship is paramount. We believe in a professional, collaborative relationship between the patient, their family, and all members of the multidisciplinary team. This relationship is based on the following principles: acceptance, individualization, client self-determination, unconditional positive regard, non-judgmental attitude, empathy, respect, controlled emotional involvement, confidentiality, and trust.

- Start where the patient is. There are many parts to recovery, resilience, and healing. Services are individualized and flexible, meeting the needs of patients and their families. Services are adapted to start where patients are now.

- Foster partnership of care. Patients and their families are encouraged and welcomed as partners in their care, using a collaborative relationship with them in the planning and delivery of all services.

- Patients should feel empowered. We seek to promote empowerment of patients, helping them become self-governing.

- Tap into the patient’s support systems and community resources. We believe in utilization of natural support systems and community resources to help meet the needs of the patients, serving them in the least restrictive community setting.

- Look to consumer-run services. We believe in the power of peer support and consumer-run services.

- Focus on patients’ strengths. We believe in teaching the patients to self-manage, focusing on their strengths, skills, and abilities to meet their needs.

LEVELS 3 AND 4: DISCHARGE PLANNING

Discharge planning begins at admission and includes coordination of follow-up and ongoing involvement with family and/or guardians. Families are provided with strategies and skills to help their loved one return to family life when they return home. Community resources and natural support systems are utilized to augment treatment and to assist in a successful transition back into the community.

- Time frames: Services are highly individualized, ranging from nine to 20 hours per week (adults) and six to 20 hours (adolescents), based on the person’s specific needs. Further services may decrease over the course of treatment as symptoms subside, with a goal of moving the patient back towards outpatient, clinic-based care and aftercare supports. Duration of treatment varies with illness severity and treatment response.

- Team members: Licensed independent practitioners, recreational therapists, psychologists, licensed mental health therapists, substance use disorder counselors, registered nurses, certified educators, recreational therapists, occupational therapists, speech/language therapists, behavioral health therapists, psychiatric technicians, dietitians, and security.

Level 2.5: Partial Hospitalization (> 20 hours/week)

Services are day treatment five to seven days per week (more than 20 hours per week). Patients are placed in the most appropriate level and then, as their condition changes, they are moved up or down the treatment continuum.

- Service components included:
  - Individualized biopsychosocial assessment: Comprehensive substance use and addictive disorder history; physical examination as determined by patient’s medical condition; and problems, needs, strengths, skills, and priority formulation for creating an individualized treatment plan.
  - Skilled treatment services: Individual and group counseling (motivational interviewing, enhancement, and engagement strategies), medication management, education groups, occupational and recreational therapy, and other therapies. Service amount, frequency, and intensity appropriate to treatment plan objectives.
  - Family therapy: Involves family members, guardians, or significant others in assessment, treatment, and continuing care.
  - Planned therapy format: Delivered on individual and group basis and adapted to the patient’s developmental stage and comprehension level.

- Time frames: Highly individualized services include interventions prescribed at >20 hours per week based on the individual’s specific needs. Further services may decrease over treatment course as symptoms subside, placing patient in a lower level of care. Duration varies with the illness severity and treatment response.

- Team members: Licensed independent practitioners, psychologists, licensed mental health therapists, substance use disorder counselors, registered nurses, certified educators, recreational therapists, occupational therapists, speech/language therapists, behavioral health therapists, psychiatric technicians, dietitians, and security.

Levels 3.1–3.5: Residential (24-hour care)

Within Intermountain, residential care is currently only available to adolescents at Primary Children’s Hospital and residential treatment centers (RTCs) for adults are not available, but integrated treatment is available through other community-based centers. In most cases, lower levels of care (day treatment or intensive outpatient) are as successful as residential treatment. Patients who benefit most from RTC services are those whose environment is dangerous or who are unable to maintain recovery (sobriety) at lower levels of care. The least restrictive level of care that meets patient need is always preferred.

Levels 3.7–4.0: Inpatient (24-hour nursing care)

Inpatient SUD care is primarily related to alcohol- and opioid-withdrawal management and referral/engagement with the next care level (treatment). Medical withdrawal management is for patients who are physiologically symptomatic at admission. As a medical service, admission must meet strict InterQual criteria, which include elevated heart rate, nausea, vomiting, electrolyte abnormalities, and/or elevated COWS score. Patients who do not meet criteria at the time of admission but appear to be inevitably moving toward severe withdrawal may be admitted as observation status.

Aftercare

Based on individual clinical and medical necessity, patients can access comprehensive services to increase functionality and realize resilience and recovery goals. Services and referrals are based on ongoing assessment and coordinated with outpatient services.

- Purpose. Recommend community and natural support systems to meet the needs of patients to function autonomously.
CHOOSING AN INPATIENT SERVICE?

Your patient’s symptoms, history, and diagnosis dictate the site and type of inpatient care required. Choose:

- Psychiatric inpatient treatment for a patient who is suicidal or has psychiatric symptoms that outweigh withdrawal issues.
- A medical detox program for patients in withdrawal. (You may admit on observation status.)

- **Time frames.** Linked to medical and clinical necessity and the patient’s response to services (usually at least 10 weeks, but can be 2+ years). Usually one to two days per week for one hour each session.
- **Service components.** Aftercare/Relapse Prevention Plan; medication-assisted treatment (as medically necessary); psychological testing (as medically necessary); individual and/or family sessions.
- **Team members.** Licensed independent practitioners; psychologists; LMHTs; substance use disorder counselors.

### Treatment modalities

Within each level of coordinated care, various treatment components should be evaluated with regard to their ability to affect the symptom and function goals appropriate to the particular stage of care of the patient. Treatment should focus on reducing situation anxiety among recovering patients in outpatient treatment. Care should ultimately be individualized to patient and may include one or more of the modalities listed in the table below. Note that some of these modalities may not be covered by the patient’s insurance; be sure to investigate coverage when planning treatment.

**TABLE 8. Treatment modalities**

<table>
<thead>
<tr>
<th>Treatment modality</th>
<th>Definition and notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated care model</td>
<td>• Monthly clinic visits with a nurse practitioner or physician. • Motivational interviewing techniques; includes family members. • Used with patients with SUD and comorbid medical problems. • Outreach attempts if person misses sessions.</td>
</tr>
<tr>
<td>Withdrawal management</td>
<td>• May be carried out in an outpatient, residential, or inpatient setting. • Includes medically supervised evaluation, withdrawal management, and referral services using a defined set of policies and procedures.</td>
</tr>
<tr>
<td>Cognitive behavioral therapy (CBT)</td>
<td>• Individual and group sessions. • Emphasizes the role of thinking and behavior in determining both cravings for drugs and the ensuing drug-seeking and use.</td>
</tr>
<tr>
<td>Medication-assisted treatment (MAT)</td>
<td>• Encompasses a variety of pharmacological treatments used to treat SUD including both agonist and antagonist medications. • As part of a comprehensive treatment plan, pharmacotherapy can help support recovery. It is essential that SUD treatment and recovery approaches address the various aspects of biological, psychological, social, and spiritual dimensions for optimum health and wellness. • See page 28 for information about specific medications.</td>
</tr>
<tr>
<td>Individual counseling</td>
<td>• Delivered in structured sessions to foster abstinence and general adjustment.</td>
</tr>
<tr>
<td>Motivational enhancement</td>
<td>• Addresses patient’s readiness for change, designed to facilitate understanding of relationship between use disorder and attendant life issues.</td>
</tr>
<tr>
<td>Random drug screens</td>
<td>• Designed to monitor progress and reinforce treatment gains.</td>
</tr>
<tr>
<td>Psychiatric treatment for comorbidities</td>
<td>• Treatment of comorbid psychiatric conditions is crucial. • Requires coordination of care among all providers and settings involved (psychiatric, behavioral, primary care, etc.).</td>
</tr>
<tr>
<td>Family involvement</td>
<td>• Marital, family, and couples therapies. (Behavior couples therapy: Treats the SUD patient with his or her spouse.) • Community Reinforcement and Family Training (CRAFT); produces greater likelihood of entry and engagement of substance abusing family members and greater likelihood of post treatment abstinence than standard treatment.</td>
</tr>
<tr>
<td>Group therapy</td>
<td>• Determined by patient need as identified by psychosocial assessment. Includes dialectical behavioral therapy; skill-specific groups; occupational and recreational therapy; tasks of daily living and recovery; parenting, gender, trauma, and other issues that impact the individual’s ability to achieve recovery goals.</td>
</tr>
<tr>
<td>Clinical case management/ wrap-around services</td>
<td>• Most patients admitted for SUD treatment have significant problems in 1 or more other areas of life function. • Wraparound services include primary medical care, housing, employment training, psychiatric care, and parenting assistance.</td>
</tr>
<tr>
<td>Recovery management check-ups</td>
<td>• Brief, regular “checkups” (e.g., every 3 months) with referral to treatment if necessary.</td>
</tr>
<tr>
<td>Voucher-based reinforcement of abstinence</td>
<td>• Greater treatment retention, more abstinent patients, longer period of abstinence, and greater personal function improvements than the standard counseling approach.</td>
</tr>
<tr>
<td>Aftercare and telephone continuing care</td>
<td>• Aftercare designed to reinforce treatment gains for patients who have completed an SUD program. • Telephone continuing care is based on an integrated treatment model of motivational interviewing and CBT; evidence-based program for adults who have recently completed an SUD program that makes continuing care accessible for those with work and transportation conflicts.</td>
</tr>
<tr>
<td>Community groups (12-step groups, SMART, Rational Recovery, SAVE, NAMI, USARA, LDS Addiction Recovery Program, Al anon)</td>
<td>• Participating in a post-treatment self-help group predicts better outcomes among day-hospitalization patients. • Specialty groups, such as women’s groups, may exist within community groups. • Online meetings are available for individuals who cannot get to regular meetings due to work schedules or geographic location. • Active promotion of spirituality is often promoted as a key to lasting recovery.</td>
</tr>
</tbody>
</table>
MEDICATION MANAGEMENT

Medications for substance use continue to be under prescribed — even in settings that include treatment for both psychiatric disorders and SUDs. However, increasing evidence and support suggests that these medications should be used in regular clinical practice and not be limited to specialty substance use disorder settings.

Important: All relapse-prevention medications should be used as part of a comprehensive treatment program of psychosocial interventions, including individual and group psychotherapy (e.g., intensive outpatient, day/residential treatment, Dayspring, etc.) and 12-step support meetings such as Alcoholics or Narcotics Anonymous.

<table>
<thead>
<tr>
<th>TABLE 9. Medications used to treat substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication</strong></td>
</tr>
<tr>
<td>Alcohol withdrawal — see page 24.</td>
</tr>
<tr>
<td>Alcohol dependence — first-line[^A]</td>
</tr>
<tr>
<td><em>acamprosate</em> (Campral)</td>
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<td></td>
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<tr>
<td></td>
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<tr>
<td>naltrexone, oral (Depade, Revia)</td>
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<tr>
<td></td>
</tr>
<tr>
<td>naltrexone, extended-release injectable (Vivitol)</td>
</tr>
<tr>
<td>Alcohole dependence — second-line and off label</td>
</tr>
<tr>
<td><em>disulfiram</em> (Antabuse)[^B]</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><em>topiramate</em> (Topamax)[^C]</td>
</tr>
<tr>
<td><em>gabapentin</em> (Neurontin)</td>
</tr>
<tr>
<td>Opioids — prevention of lethal overdose, FDA-approved[^A]</td>
</tr>
<tr>
<td><em>naloxone</em> (Narcan, Evzio)</td>
</tr>
<tr>
<td>Narcan Nasal Spray</td>
</tr>
<tr>
<td>Naloxone rescue kits are available for intranasal administration and IM injection</td>
</tr>
<tr>
<td>Auto-injector (Evzio) for IM or subcutaneous (SQ) injection</td>
</tr>
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<td></td>
</tr>
</tbody>
</table>

[^A]: Available in generic form.
[^B]: In 2014, the FDA approved extended-release disulfiram (Antabuse) for alcohol dependence in adult patients with a diagnosis of alcohol dependence who are motivated to remain alcohol free. It was previously indicated only for patients with alcohol dependence who were able to abstain from alcohol in an outpatient setting prior to initiation. Receipt of a prescription for this approved use requires a unique identifier assigned by the prescriber’s state or region. A separate prescriptions is required for the off-label indications for disulfiram: (1) when blood alcohol is at least 0.05% on urine alcohol testing 12 hours after last drink of alcohol, and (2) to minimize alcohol-induced flushing and other effects of alcohol consumption. In 2015, the FDA approved extended-release topiramate (Topamax) for alcohol dependence in patients able to abstain from alcohol in an outpatient setting prior to initiation.
[^C]: See page 24 for discussion of disulfiram and topiramate.

[^C]: https://www.pewtrusts.org/system/files/2016/12/14/workingpaper_alcoholdependencefdaapproval.pdf
### TABLE 9. Medications used to treat substance use disorder, continued

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opioid withdrawal and dependence</strong>&lt;sup&gt;APA1,APA2&lt;/sup&gt; (relapse rates are 75%–85% after 1 year)&lt;sup&gt;APA2,APA3&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buprenorphine and naloxone 4:1 ratio (Suboxone, Zubsol) sublingual tablets and film</td>
<td><strong>Initial dose:</strong> 4 mg buprenorphine (max: 8 mg)&lt;br&gt;<strong>Titrations:</strong> Up to 16 mg daily&lt;br&gt;<strong>Maintenance:</strong> 16 mg daily (range: 4–24 mg daily) based on buprenorphine&lt;br&gt;<strong>Max:</strong> 32 mg/day</td>
<td>• Federal and state regulations in place; programs using this agent for opioid use disorder must be registered with CSAT within SAMHSA.&lt;br&gt;• Treating physician must apply to SAMHSA for permission to prescribe for opioid addiction; limits on number of patients per prescriber; requires waiver to Controlled Substance Act, second DEA number.&lt;sup&gt;APA1&lt;/sup&gt;&lt;br&gt;• Can be used for short-term detox, but relapse rates are very high; best used as a maintenance medication.&lt;br&gt;• Less abuse potential vs. buprenorphine alone; buprenorphine is a partial agonist at mu opioid receptor; sublingual naloxone is inactive.&lt;br&gt;• Preferred in outpatient setting, office-based prescribing and retail pharmacy dispensing permitted.&lt;br&gt;• Per FDA-required REMS, patient medication guides are available at &lt;www.fda.gov/downloads/Drugs/DrugSafety/UCM225677.pdf&gt; and &lt;www.zubsolrems.com/pdf/zubsolMedicationGuide.pdf&gt;.&lt;br&gt;• Studies report treatment is safe, effective for mother and newborn; reduced neonatal abstinence syndrome severity vs. methadone.</td>
</tr>
<tr>
<td>Buprenorphine (Subutex) sublingual tablets</td>
<td><strong>Initial dose:</strong> 4 mg (max: 8 mg)&lt;br&gt;<strong>Titrations:</strong> Up to 16 mg daily&lt;br&gt;<strong>Maintenance:</strong> 16 mg daily (range: 4–24 mg daily)&lt;br&gt;<strong>Max:</strong> 32 mg/day</td>
<td>• Federal and state regulations in place; programs using this agent for opioid use disorder must be registered with CSAT within SAMHSA.&lt;br&gt;• Treating physician must apply to SAMHSA for permission to prescribe for opioid addiction; limits on number of patients per prescriber; requires waiver to Controlled Substance Act, second DEA number.&lt;sup&gt;APA1&lt;/sup&gt;&lt;br&gt;• Can be used for short-term detox but relapse rates are very high; best used as a maintenance medication.&lt;br&gt;• Studies report treatment is safe, effective for mother and newborn; reduced neonatal abstinence syndrome severity vs. methadone.</td>
</tr>
<tr>
<td>Methadone (Methadone, Dolaphine) oral tablet, dispersible tablet, solution intravenous, subcutaneous, and intramuscular formulations also available</td>
<td><strong>Transition to methadone on an inpatient unit</strong>&lt;br&gt;<strong>Day 1:</strong> Give 20–30 mg dose, then doses of 5–10 mg as needed (max: 40 mg), then titrate by 10–20 mg daily to 60–80 mg daily</td>
<td>• Any outpatient use of methadone must be through a federally licensed methadone clinic. If used in the hospital, methadone can be used if treating an additional diagnosis besides SUD (pregnancy, cellulitis), Methadone can not be prescribed at discharge. The patient must go to a federally licensed program.&lt;br&gt;• Federal and state regulations in place; programs using this agent for opioid use disorder must be registered with CSAT within SAMHSA and the DEA.&lt;br&gt;• Black box warning for cardiac arrhythmias; FDA recommends patients be informed of risk and asked about history of structural heart disease, arrhythmia, or syncope.&lt;br&gt;• Side effects: constipation, drowsiness, excess sweating.&lt;br&gt;• Pregnancy: standard of care; reduces fetal harm risk vs. continued illicit drug use; decreased clearance in second and third trimesters, so increased dose is needed if/when withdrawal symptoms occur, and dose should be decreased after delivery.&lt;br&gt;• Excreted in breast milk, but may use during breastfeeding.&lt;br&gt;• Pretreatment ECG, repeat within 30 days and annually; additional monitoring if dose ≥ 100 mg/day or QTc 450–500 msec.</td>
</tr>
<tr>
<td>Naltrexone, oral (Depade, ReVia)</td>
<td><strong>Day 1:</strong> 25 mg; if no withdrawal signs, 50 mg daily thereafter</td>
<td>• See notes on page 28. • Do not begin until patient is opioid-free for at least 7–10 days. • Reduces craving and decreases relapse.</td>
</tr>
<tr>
<td>Naltrexone, extended-release injectable (Vivitrol)</td>
<td>380 mg IM every 4 weeks (or once monthly) for a minimum of 6–12 months</td>
<td>• See notes on page 28. • Do not begin until patient is opioid-free for at least 7–10 days.</td>
</tr>
<tr>
<td>Clonidine (Catapres)&lt;sup&gt;APA1&lt;/sup&gt;</td>
<td>0.05–0.1 mg 3 times daily (can be higher in inpatients), increase to max of 1.2 mg daily</td>
<td>• Use for withdrawal (not FDA-approved); not used for maintenance.&lt;br&gt;• Reduces withdrawal symptoms; duration is usually 4–6 days for short-acting opioids (e.g., heroin); does not reduce drug cravings.&lt;br&gt;• May use higher doses for closely monitored inpatients.</td>
</tr>
<tr>
<td>Tobacco — FDA approved&lt;sup&gt;APA1,APA3&lt;/sup&gt;</td>
<td><strong>Nicotine replacement therapy (NRT): patch, gum, lozenge, nasal spray, oral inhaler</strong>&lt;br&gt;<strong>Nicotine spray:</strong> 0.5 mg/30 ml (8–40 times daily; max 5/ hour); use for 3–6 months then taper&lt;br&gt;<strong>Inhaler:</strong> 6–16 cartridges daily up to 6 months then taper&lt;br&gt;<strong>Select dosage and form based on patient preference.</strong> <strong>Nicoral spray and oral inhaler are by prescription only.</strong> <strong>Using a combination of first-line agents may improve outcomes.</strong>&lt;sup&gt;APA1&lt;/sup&gt;</td>
<td>• OTC products: use per package instructions, based on number of cigarettes daily.&lt;br&gt;• NRT: 1 patch (7 mg/21 mg) for every 24 hours.&lt;br&gt;• Nicorette gum (2 mg): chew and “park” 1 piece every 1–2 hours (max 24 pieces daily) for up to 12 weeks.&lt;br&gt;• Nicorette lozenge (2 mg): 1 piece every 1–2 hours over 4–6 weeks.&lt;br&gt;• Nicorette inhaler (1 mg/ puff): 1 puff every 1–2 hours over 4–6 weeks.&lt;br&gt;• Nicorette chewing gum (4 mg): chew and “park” 1 piece every 1–2 hours over 4–6 weeks.&lt;br&gt;• Nicorette spray (5 mg): 1 spray every 1–2 hours over 4–6 weeks.&lt;br&gt;• Contraindicated in patients with seizures disorders, bulimia, anorexia.&lt;br&gt;• Available in 150 mg, 300 mg XL tablets (once-daily dosing); XL form is not FDA approved for smoking cessation.&lt;br&gt;• Warnings: neuropharmacological reactions, suicidal thoughts and behaviors.&lt;br&gt;• Using a combination of first-line agents may improve outcomes.&lt;sup&gt;APA1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Bupropion SR (Zyban, Wellbutrin SR)</td>
<td><strong>Days 1–3:</strong> 150 mg every morning&lt;br&gt;<strong>Day 4 onwards:</strong> may increase to 150 mg twice daily&lt;br&gt;<strong>Max dose:</strong> 150 mg every other day due to hepatic impairment (Child-Pugh Score: 7–15)</td>
<td>• Begin dosing 1 week before quit date.&lt;br&gt;• SR doses must be at least 8 hours apart; take second pill in late afternoon/early evening to reduce insomnia.&lt;sup&gt;APA1&lt;/sup&gt;&lt;br&gt;• Continue for 7–12 weeks; some patients may need ongoing treatment.&lt;br&gt;• If patient has not quit after 7–12 weeks, it is unlikely patient will quit during this attempt; discontinue bupropion.&lt;br&gt;• Contraindicated in patients with seizures disorders, bulimia, anorexia.&lt;br&gt;• Available in 150 mg, 300 mg XL tablets (once-daily dosing); XL form is not FDA approved for smoking cessation.&lt;br&gt;• Warnings: neuropharmacological reactions, suicidal thoughts and behaviors.&lt;br&gt;• Using a combination of first-line agents may improve outcomes.&lt;sup&gt;APA1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Varenicline (Chantix)</td>
<td><strong>Days 1–3:</strong> 0.5 mg once daily&lt;br&gt;<strong>Days 4–7:</strong> 0.5 mg twice daily&lt;br&gt;<strong>Days 8 onwards:</strong> 1 mg twice daily&lt;br&gt;<strong>Max dose:</strong> 0.5 mg twice daily due to renal impairment (CrCl &lt;30 mL/min)</td>
<td>• Research indicates a consistently higher quit rate than use of nicotine replacement therapy or bupropion SR.&lt;sup&gt;APA1&lt;/sup&gt;&lt;br&gt;• Initiate at least 1 week before target quit date or start per dosing and quit smoking between days 8 and 25.&lt;br&gt;• Use for a total of 12 weeks; additional 12 weeks recommended if effective.&lt;br&gt;• Trouble some side effects include nausea (28.1% of patients), headache, insomnia, and abnormal dreams.&lt;sup&gt;APA1&lt;/sup&gt;&lt;br&gt;• Warning for rare neuropharmacological events, suicidal ideation or behavior.</td>
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</tbody>
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LEARNING TO SHARE

SAMHSA has provided a number of documents and materials that address issues related to the sharing of substance use disorder treatment information under 42 CFR Part 2.

Find them here: samhsa.gov/healthprivacy

TALKING POINTS AT ADMISSION

Federal and state law protect patient privacy in all the ways outlined in the PHI Release Consent Form — and summarized at right.

Besides ensuring that your patients understand these rights, it’s a good idea to explain the following to patients at admission to treatment:

• The patient shouldn’t have “secrets” about substance use. It’s important that the patient be open with the team.
• The patient (and the patient’s family) has the right to not answer any question posed in treatment. However, openness and honesty are important to treatment and recovery.

ISSUES AND CHALLENGES

Sharing patient records: protections and permissions

HIPAA allows for information sharing between organizations for the purpose of healthcare coordination. To feel comfortable with sharing information under HIPAA, partnering organizations often enter into more formal relationships to share information. Section 160.103 of HIPAA describes this arrangement. Additionally, drug and alcohol treatment records have special protections granted under Federal Law 42 CFR Part 2. These specify that:

• When patients are admitted to a treatment facility, staff should solicit their signature on the Consent for Release of Chemical Dependency Treatment Information To Healthcare Providers and Healthcare Insurers form (the PHI Release Consent). (Note that a general Authorization for the release of medical records is not sufficient for the purpose of releasing drug and alcohol treatment records.) The signed PHI Release Consent form indicates consent to allow records to be used for verification of benefits, payment issues or to be able to share treatment information with others.

− Patients must be told clearly and specifically that their SUD treatment records are part of their medical record — but that these records are protected in compliance with Federal Regulation 42 CFR Part 2. This means that the only people who will have access to information about a patient’s SUD treatment are staff who handle benefits and payment issues, members of the patient’s SUD treatment team — and people specifically authorized by the patient. (See the next major bullet for more on authorization.)

− Patients should know that their PCP is generally not part of the treatment team that will have access to patient information. If the patient wants to involve his or her PCP, the patient must specifically name the PCP on the signed form.

− Patients should be given the Notice of Privacy Rights For Substance Use Disorder Records form, which identifies their legal rights within the treatment program. The form states that they can expect the treatment program to comply with privacy rules outlined in the PHI Release Consent Form (violation is a federal crime) and that they can expect to be held legally responsible for any crimes they may commit at the program or against a person in the program.

− Adolescents age 16 and 17 must sign the PHI Release Consent Form, along with their parents/custodians.

• Each person to be allowed access to treatment information must be specifically named by the patient before any treatment information can be shared. The only situations in which drug and alcohol treatment records can be disclosed without specific patient authorization are when:

− Medical personnel are treating a patient during a medical emergency (only to the extent necessary for treatment).

− Qualified individuals are conducting approved research.

− There is a need to facilitate management/financial audits or program evaluation. Patient information must be de-identified.

− Reporting crimes or threats of crimes on the treatment premises or against treatment personnel. Information must be limited to information directly relating to the crime or threat, circumstances, individual’s name and address, patient status, and last known whereabouts.

• When disclosing drug and alcohol treatment records, this statement must accompany the record:

“This information is being disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.”
Payment issues
Payment for substance use treatment usually occurs in these ways:
• Self-pay for all or part of treatment
• Coverage via commercial health insurance
• Coverage by public assistance (Medicaid or Medicare)

The Affordable Care Act (ACA) increased the services available to many patients. Prior to the ACA, one-third of those covered in the individual market did not have coverage for SUD services. The ACA includes SUD coverage as one of its 10 essential benefits. It builds on the Mental Health Parity and Addiction Act of 2008, which ensured that coverage of mental health and SUDs is comparable to medical and surgical care. The ACA requires that benefit packages include SUD services, prescription drugs, rehabilitation, and prevention and wellness services.

Coverage for treatment of SUD may derive from different areas of a person’s benefit plan. The medical withdrawal management phase of treatment is often in the medical benefit portion of an insurance plan and the SUD treatment is in the mental health benefit. This separation of benefit source can lead to confusion about coverage and should be coordinated with the insurance provider.

MEASURING CPM SUCCESS

The goal of Intermountain’s Substance Use Disorder (SUD) Care Process Model is to facilitate identification and treatment of patients with SUD through enhanced access to mental health and SUD services, consistent clinical processes, team-based care, and rigorous evaluation. These efforts are designed to raise clinician awareness of SUD, leading to greater identification of patients and subsequent referrals into treatment — in essence, the right care, for the right patient, at the right time.

The purpose of program evaluation is to measure whether this approach to SUD is effective in reaching these goals, determine which factors are contributing to the program’s success, and recommend program changes. Specific measures are listed below.

<table>
<thead>
<tr>
<th>TABLE 10. Measures</th>
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<tr>
<td><strong>Area</strong></td>
</tr>
<tr>
<td>Patient IDENTIFICATION</td>
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</tbody>
</table>
| Patient PARTICIPATION in treatment | Number of patients with moderate- to high-risk SUD who:  
• Are referred to a higher level of care.  
• Have first SUD treatment within 14 days from initial diagnosis (time frame per the Healthcare Effectiveness Data and Information Set (HEDIS).  
• Have at least 2 visits within 30 days of treatment initiation (per HEDIS).  
• Have at least 3 visits within 44 days of treatment initiation (per HEDIS). |
| IMPLEMENTATION | • Number of providers and clinics who develop a process for SUD screening and referral.  
• Number of locations that offer SUD treatment. |
| Clinical OUTCOMES | • Number of prescriptions for opioid medication for patients identified as having prescription drug SUD.  
• Level of patient functioning: Functional disability rating scale scores for patients identified with prescription drug use disorder at baseline and at 90 days, 180 days.  
• Opioid medication use: Number of opioid pills per month prescribed for patients identified with prescription drug use disorder at baseline and at 90 days, 180 days. |
| Healthcare UTILIZATION | • Number of patients seen in primary care setting with evidence of SBIRT based on chart review.  
• Mean number of days from initial diagnosis of SUD to first appointment with higher level of care.  
• Number of high-risk alcohol patients referred to higher level of care.  
• Number of high-risk alcohol patients seen within 14 days of initial visit. |
RELATED CARE PROCESS MODELS (CPMs):

- Opioid Use in the Lactating Mother CPM
- Opioid Use in Pregnancy CPM
- Management of Depression CPM
- Chronic Non-cancer Pain CPM
- Eating Disorders CPM
- Bipolar Disorder CPM

RESOURCES

Patient education resources
Table 6 on page 22 lists the patient and family education materials recommended to support SUD prevention and management at Intermountain.
To access these materials:

- Log in to Intermountainphysician.org/PEN, and search for the item number or title in the appropriate area.
- In the iCentra EMR system, search for Intermountain items in the patient education module.
- Use the iprintstore.org, Intermountain’s Online Library and Print Store, for one-stop access and ordering for all Intermountain materials (fact sheets, booklets, trackers, etc.): iprintstore.org.

Provider resources
To find this CPM, its reference list, and other resources, clinicians can go to:

- Substance Use Disorder topic page, which is available from the Behavioral Health Clinical Program page of intermountainphysician.org.
- Printed materials can be ordered from iprintstore.org.

External Resources
Access third-party resources as follows:

- Adult and Adolescent Level of Care Index (LOCI-3 and LOCI-2R) assessment forms: Order from changecompanies.net. Allow 4–6 weeks for orders to arrive.
- The ASSIST-linked Brief Intervention for Hazardous and Harmful Substance Use for additional language and tips for talking to patients. For adolescents, access the CRAFFT screen in English and 12 other languages.
- CDC Opioid Prescribing Guidelines

Mental Health Integration resources
On intermountainphysician.org, click the Mental Health Integration topic page from the Primary Care Clinical Program page.
REFERENCES


CSAT Center for Substance Abuse Treatment. Substance abuse treatment for persons with co-occurring disorders. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005.


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